U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

Advisory Committee for Women's Services (ACWS)

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VTC Room, Lobby Level
1 Choke Cherry Road
Rockville, MD

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Committee Members Present:

Nadine Benton, Acting DFO
Sharon Amatetti, Acting Chair
Johanna Bergan
Jean Campbell
Vincent J. Felitti
Harriet C. Forman
Shelly F. Greenfield
Velma McBride Murry
Starleen Scott Robbins
Carole Warshaw

Other Participants:

Sara Afayee
Brian Altman
Deborah Baldwin
Mary Blake
John J. Campbell
Nevine Gahed
Irene Goldstein
Olinda Gonzalez
Anne M. Herron
Pamela J. Hyde, SAMHSA Administrator
Josh Shapiro
Sarah Wurzburg

PROCEEDINGS

Agenda Item: Call to Order

MS. NADINE BENTON: Good morning. The Advisory Committee for Women's Services meeting is hereby called to order, Ms. Sharon Amatetti chairing the meeting.

But before I turn the meeting over to Sharon, I would like to especially thank Josh Shapiro and his team for their diligence in making sure that this meeting runs smoothly.

Sharon?

MS. SHARON AMATETTI: Okay. Thank you very much.

Good morning, everybody. Nadine, you didn't introduce yourself.

MS. NADINE BENTON: I'm Nadine Benton. I apologize.

MS. SHARON AMATETTI: Nadine is the Acting Designated Federal Official for our meeting today. So we're very happy that she's stepped into this role. Geretta Wood has retired, and so we miss Geretta, but we're happy that Nadine is here.

And good morning, everybody. I'm Sharon Amatetti. I know all of you now because we've been meeting like this for some time, but I'm just really glad that everybody is here this morning.

Some housekeeping just before I get started. We are all on mikes, and I was told that even side conversations will be picked up by mikes. Unlike some of our meetings where we press the button to be heard, this room is a little bit different. I specifically asked for this room because of the windows, which is nice. But the miking is a little bit tricky. So I just wanted to let you know that you -- you are probably going to be picked up if you have a side comment.

I obviously am not Kana Enomoto. I am Sharon Amatetti, and the reason that I'm chairing the meeting today is because Kana is traveling overseas. And she --

OPERATOR: Sharon, are you ready to get started?

MS. SHARON AMATETTI: I am.

OPERATOR: Okay. We'll go ahead and place you into conference mode

momentarily, and again, I'll turn it over to Ms. Sharon Amata -- Amati?

MS. SHARON AMATETTI: Amatetti.

OPERATOR: Amatetti. Thank you.

MS. SHARON AMATETTI: Thank you very much, Julie.

[Music playing in background.]

MS. SHARON AMATETTI: Julie is our operator, and she's controlling the telephone participants. So Kana wanted to just extend her greetings to all of you and thank you for coming and say that she will be happy to see you at our next meeting.

Just for the record --

OPERATOR: Welcome, and thank you for standing by. All participants will be on listen-only mode until the question and answer portion. Today's conference is being recorded. If you have any objections, please disconnect at this time.

I would now like to turn the conference over to Ms. Sharon Amatetti. Ma'am, you may begin.

Agenda Item: Welcome Members and Roll Call

MS. SHARON AMATETTI: Thank you very much, Julie.

And for those of you on the phone, I'm Sharon Amatetti, the SAMHSA Women's Issue Coordinator, chairing the meeting today on behalf of Kana Enomoto. And our Designated Federal Official is Nadine Benton, who is acting in that role because of the retirement of Geretta Wood.

So just for the record, I wanted to let the record reflect who is here in the room today. We have Johanna Bergan. We have Harriet Forman, Starleen Scott Robbins, Vincent Felitti, Velma McBride Murry, Carole Warshaw, Jean Campbell, and Shelly Greenfield representing our advisory committee membership.

We have Nadine Benton, as I mentioned. Other staff in the room from SAMHSA include Ingrid Donato, Brian Altman, Deborah Baldwin, Nevine Gahed. And we have staff assisting us. We have Josh Shapiro from our contractor. Irene is here this morning. Christine is helping us with the mikes.

And we have some visitors from NASADAD who will introduce themselves later, I

hope.

Agenda Item: Remarks by the Associate Administrator for Women's Services and Adoption of Minutes for the April 10, 2013 Meeting

MS. SHARON AMATETTI: So good morning, everybody.

[Response.]

MS. SHARON AMATETTI: As you know, we always start with the adoption of the minutes from the last meeting. Okay? So these minutes were certified in accordance with the Federal Advisory Committees Act regulations. Members were given an opportunity to review and comment on the draft minutes. Members also received a copy of the certified minutes.

If you have any changes or additions, they'll be incorporated in this meeting's minutes -- the minutes from this meeting. If not, can I have a motion to approve the minutes?

MS. HARRIET C. FORMAN: So moved.

REPORTER: Who moved it, please?

MS. HARRIET C. FORMAN: Harriet Forman.

REPORTER: Thank you.

MS. SHARON AMATETTI: And a second?

MS. STARLEEN SCOTT ROBBINS: Second. Starleen.

MS. SHARON AMATETTI: Thank you.

And when you do speak, especially this morning, if you could say your name in advance, that would be very helpful for people on the phone as well as for those people who are recording what we are saying and documenting it.

So the minutes are approved, and thank you very much.

Before we get started today, I wanted to quickly review our agenda. I think we have a really good meeting planned. I'm excited about it. The agenda is in your binder. Have you all found the material in your binder that relates to this meeting? It contains information about the joint meeting as well as the advisory

committee for today, which is towards the back of the book.

So after my report on behalf of Kana, the committee will be asked to provide updates about what you're doing or issues that you feel are important for the committee to consider. So please be thinking about that over the next few minutes about what you want to say.

You will then hear a brief update about the SAMHSA Women's Coordinating Committee from myself and my colleague Mary Blake, who's going to be joining us. Following that, we have SAMHSA colleagues who are here to speak about the block grants and health reform and how they relate to women's services, and then we'll have a discussion after that.

Then comes lunch. Next, advisory committee member Starleen Scott Robbins and Sarah Wurzburg from NASADAD are going to present on the Women's Services Network, and we'll have a discussion with them.

Following the break after that, Administrator Hyde will be joining us for a discussion on SAMHSA of the future. So that should be exciting conversation. She's eager to hear your ideas about that.

And then after break, at 4:00 p.m., our advisory committee member Dr. Shelly Greenfield will share her work on the Women's Recovery Group Study, followed by a discussion of your work, Shelly. And then we have our public comment, and we adjourn for the day.

So that's what is ahead today. I just wanted to share with you some information that Kana has left for us to report about. She wanted me to share some information about the budget appropriations bills, and Brian Altman is also here to be available if there are any questions about the bill.

So, on Thursday, July 11th, which happens to be my birthday --

[Laughter.]

MS. SHARON AMATETTI: -- the Senate Appropriations Committee passed the FY '14 LHHS appropriations bill, and LHHS stands for Labor, Health and Human Services, and Education. And so far, the bill has not been brought to the Senate floor for any action. The Senate Appropriations Committee-passed bill included a total SAMHSA program level of $3.62 billion, which is compared to SAMHSA's current operating plan level, post sequestration, of $3.35 billion and the FY '12 total program level of $3.57 billion.

The Senate Appropriations Committee-passed bill included $95 million of the $130 million that was requested for the Now is the Time initiative, which is the President's plan to protect children and communities from gun violence, which

includes Project AWARE, which is a school initiative, and also mental health first aid for teachers. So we'll see where that goes.

The House LHHS Appropriations Subcommittee scheduled a markup of the FY '14 bill for late July, but then cancelled the markup the day before it was scheduled for, and no new date has been scheduled. The House Appropriations Subcommittee has an allocation for its bill that's 22 percent lower overall than the allocation for the bill that was marked up by the Senate.

Just before Congress recessed for August, the House and Senate each tried to pass their own versions of an appropriation bill to fund the Department of Transportation and Housing and Urban Development. Both houses of Congress failed to pass these usually popular and less controversial bills. Thus, it's extremely unlikely that the LHHS bill will move forward in the House or Senate, and SAMHSA will continue to operate under a continuing resolution for FY '14.

In the short term, most congressional watchers expect a 2-month short-term CR from October 1st to December 1st. However, unless there is a major grant bargain during the late fall, a full-year CR is likely. Such a CR would be at 2 percent lower than SAMHSA's current operating level, given the FY '14 targets for sequestration.

So there we are.

DR. CAROLE WARSHAW: So you're saying there will be even more sequestration cuts for next year?

MS. SHARON AMATETTI: I didn't say that.

DR. CAROLE WARSHAW: No? What's the 2 percent lower?

MR. BRIAN ALTMAN: So in the -- this is Brian Altman.

In the Budget Control Act, which set up the Super Committee, which failed to reach agreement and then triggered sequestration, failure to meet any other grand bargain, for each fiscal year, they set out lower and lower nondefense and defense discretionary spending limits. And so, as the fiscal years move forward, those limits on -- for us, nondefense discretionary spending, get lower.

So the import would be that the sequestration amount would increase slightly by the -- in order to meet the actual targets for lower spending.

MS. SHARON AMATETTI: So some legislative updates. A couple of bills are making the rounds on the Hill that are related to women and girls' issues. It doesn't mean that they're going to become law. It means that they've been introduced. And even if they do become law, it doesn't mean that they have an

appropriation attached to them. So those two things have to take place for these to become a reality. But we wanted to give you some update about some laws that have been introduced.

On May 22nd, Representative Ted Deutch -- he's a Democrat from Florida -- introduced the Federal Response to Eliminate Eating Disorders Act of 2013. And this bill would require the Director of the National Institutes of Health to take certain action regarding eating disorder research. It requires the Secretary of HHS, acting through the Director of the CDC, to provide for the collection, analysis, and reporting of epidemiological data on eating disorders, to establish a Center of Eating Disorder Epidemiology to collect and analyze information on eating disorders, and to establish a CDC clearinghouse for the collection and storage of data generated under the act.

It also sets forth requirements for providing education and training on eating disorders. It amends the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Service Code to require a health plan that provides medical and surgical benefits to also provide coverage for eating disorders and applies such requirements to coverage offered under the Federal Employee Health Benefit Program.

It amends Medicaid to expand coverage for eating disorders, and it requires the Secretary, acting through the Director of the Agency for Healthcare Research and Quality, to award grants for patient advocacy to help individuals with eating disorders obtain adequate healthcare services and insurance coverage. So for those of you interested in eating disorder issues, that might be something that you want to look into further.

I also want to let you know that on May 24th, Representative Matt Cartwright, Democrat from Pennsylvania, introduced the Access to Substance Abuse Treatment Act of 2013, which, among other provisions, would revise the grant program to provide residential substance abuse treatment to pregnant and postpartum women, which is a SAMHSA program, that would make caregiver parents eligible for such programs. That's instead of only pregnant and postpartum women.

It also makes Indian tribes and tribal organizations explicitly eligible for grants and sets forth a priority for allocation of grants, prioritizing it by pregnant and postpartum women first, then single parents, and then any caregiver parent.

Also for areas with a shortage of family treatment or high rates of heroin, cocaine, or methamphetamine addiction, there would be priority for those populations. So that would be a change to our program should it pass.

Wanted to let you know about the National Conference on Mental Health. So the National Conference on Mental Health, the White House -- and you probably

-- I expect most of you have heard about this. The White House hosted the national conference on June 3rd to discuss mental health issues. The event attendees included faith leaders, youth-serving agencies, mental health service providers, congressional representatives, and business leaders.

And during the national conference, the President and Vice President gave remarks about mental health and challenged the Nation to join the conversation and help individuals to access treatment if needed. The White House conference produced a fact sheet highlighting public and private sector partnerships to help support the nationwide conversation about mental health.

MentalHealth.gov was established, a new Web resource which was launched that same day, to provide basic information and resources about mental health. And the Web site was created through a partnership between several Federal agencies and is coordinated through the Assistant Secretary of Public Affairs Office.

We have a toolkit for community conversations about mental health that we will provide to you later today. SAMHSA released the toolkit on July 24th to assist communities in holding productive conversations about mental health using three components of the toolkit -- a planning guide, a discussion guide, and an information brief. The toolkit was created through a partnership with several Deliberative Democracy organizations, and the entire toolkit will be available in Spanish soon.

DR. JEAN CAMPBELL: This is it.

MS. SHARON AMATETTI: That's it. Was it all provided already? Okay. Good. I was looking for it on the table. I didn't see it. Great. Thank you.

Yes, I'm very happy to get any feedback you have about that toolkit.

We also have community conversations going on about creating solutions that include several partnering organizations who have come together to support cities and mayors to hold events with hundreds of residents to discuss mental health issues in their communities. These meetings are not Federal meetings. However, the SAMHSA regional administrators, along with other national partners, have and will participate in the meetings.

There was a meeting in Albuquerque, New Mexico, and Sacramento, California. They held their community meetings in July. Yolanda -- I'm not sure if you heard about those or not?

MS. HARRIET C. FORMAN: No, I've been in Wisconsin.

[Laughter.]

MS. SHARON AMATETTI: Okay: The two SAMHSA regional administrators in these locations attended and report that the demographics were great in both cities, with a broad, diverse racial and ethnic presence there. In Sacramento, for example, there were 450 participants, 30 percent of whom were ages 13 to 24, and approximately 70 percent were female.

The Mayor, Kevin Johnson, and Representative Doris Matsui were there, and a former NFL player, Tony Edwards. He gave an inspiring talk about his personal connection to mental health issues through his family, and he's now sort of an NFL ambassador and promotes a variety of approaches to emotional health and well-being, including mental health first aid. He also has a company, Beyond the Locker, which promotes community health approaches including the arts and sports. So it's great that he turned out.

Both cities received good media coverage, and there was a sense that people are really coming together for meaningful discussions surrounding mental health and emotional health.

In Kansas City, they'll hold their meetings in September on the 21st. Washington, D.C., and Akron, Ohio, will hold meetings in the near future, date to be announced. And additional communities are planning grassroots community conversations and posting information on the CreatingCommunitySolutions.org Web site, including the location and date of those events. So we'll be looking to see when those are scheduled and can share that with you in the future.

Some personnel changes. As I mentioned, Geretta Wood retired after some health concerns. So we didn't have a chance to say good-bye to her in an official way, but we appreciate her service to this committee and her service to SAMHSA. And as we mentioned, Nadine is going to be the acting contact for this advisory committee, and she's also the person you should ask of any logistics questions that you might have.

In OPPI, our Director is still Anne Herron is acting, and we're working on getting that position filled. All three centers are looking to fill their Deputy Director positions. Actually, one of them was filled yesterday. Mike Etzinger, who was CSAP's Deputy Director, is now serving as the Director in the Office of Management, Technology, and Operations, replacing Elaine Parry, who just retired after serving the Federal Government for 42 years.

Rich Kopanda, the Deputy in CSAT, just retired last week, I believe, or the week before. And Anna March, Deputy Director at CMHS, also just recently retired as well. All of them after long Federal careers. And Mirtha Beadle, who had been acting as a Deputy to Administrator Hyde, it was just announced that she's going to be the Deputy in CSAP. So that's a new thing for us and look forward to having her service in CSAP.

Okay.

[Laughter.]

MS. SHARON AMATETTI: How am I doing for time? We'll see.

Some reports. We have some new data reports. There is a TEDS data, Treatment Episode Data Set, trends in substance abuse among pregnant women and women of child-bearing age in treatment. It's on the desk over there. Looks like this.

And according to the data from this Treatment Episode Data Set, the proportion of female substance abuse treatment admissions who were pregnant stayed fairly stable. It's always between 4 and 5 percent. But there were shifts in the type of substances reported by these treatment admissions.

The percent of pregnant admissions reporting alcohol abuse went down, but the percent of women reporting drug abuse other than alcohol went up. This may reflect that women are receiving information about the danger of alcohol use during pregnancy but not similarly aware of the dangers of other drug abuse or are shifting their drug of choice.

We are working on another report on Fetal Alcohol Spectrum Disorder. CBHQS is preparing a spotlight in anticipation of FASD Awareness Day, which is coming up on September 9th, that will highlight the rates of alcohol use by trimester.

Our National Survey on Drug Use and Health data showed that up to 20 percent of pregnant women consume alcohol during their first trimester, often when they are unaware that they are pregnant. By the second trimester, this goes down to 6.5 percent and 3.5 percent in the last trimester. So there's important prevention implications there. So we're trying to -- we're going to get that out in conjunction with FASD Awareness Day in September.

So I wanted to let you know that our next advisory committee meeting and the Joint NAC is going to be held on April 16th and 17th, and that's going to be a face-to-face meeting here again. And then our future fall meeting next August or September is actually going to be a virtual meeting. We'll keep you informed about that. We did that once before. We had a virtual meeting. It was -- it had positives and negatives.

[Laughter.]

MS. SHARON AMATETTI: You know, it's hard to stay connected as long, but I think that this group did a really good job of staying tuned in. It meant that you didn't have to travel, which was nice. So we're trying to do some economies, and

that's one of the ways that we're going to be doing that. So just keep those dates in mind, if you would.

Okay.

DR. JEAN CAMPBELL: I had a request that may -- I think would go here now. In CMHS, they have this wellness -- promotion of wellness initiative, and they send out announcements through the -- through email that I thought it would be good to have people here get because a lot of them have implications for women, and they have this initiative called Wellness Awareness Week. And it would be good to report on that as part of this meeting because, again, people here -- I mean, I found out about the implications for women last year by attending a webinar that was offered during this Wellness Week for depression and congestive heart failure that was presented that was excellent.

MS. SHARON AMATETTI: That's a wonderful suggestion, Jean. Thank you.

DR. JEAN CAMPBELL: Yeah, and I'm not sure. But I think Wilma Townsend is still heading that up. But I thought that that could expand the emphasis on health and wellness as well as treatment of disease and illness.

MS. SHARON AMATETTI: Exactly. And that's the type of thing that the SAMHSA Women's Coordinating Committee can see that we share that information more broadly.

DR. JEAN CAMPBELL: Yeah.

MS. SHARON AMATETTI: Thank you for that suggestion.

Does anybody else have any comments before we go into your individual hellos and introductions?

DR. VELMA MCBRIDE MURRY: I have a question. I'm Velma McBride Murry. Are there efforts included in these -- in this toolkit to evaluate its impact?

MS. SHARON AMATETTI: Ingrid, I'm going to turn that over to you.

MS. INGRID DONATO: Well, that's a very good question. My name is Ingrid Donato. I'm Chief of the Mental Health Promotion Branch. I'm standing in for Wendie Veloz, who is spearheading these efforts, who is, unfortunately, out sick today. So --

REPORTER: Can you move closer to the table?

MS. INGRID DONATO: Closer?

MS. SHARON AMATETTI: Yeah.

MS. INGRID DONATO: Oh, okay. So there were a lot of discussions early in the planning of this to introduce elements of evaluation throughout it. But the intent of the Federal participation in these -- in these community conversations was really just to start the ball rolling and then to step back and let the communities take over. And so, there wasn't an explicit evaluation component built into it, but I believe that once the private partners and the community leaders step in, there will be individual evaluation of their particular activities.

So, at a Federal level, it was a conscious decision that we weren't going to play that role, that we were just going to introduce these concepts and support them and that it would be up to our private and community partners to take the ball and lead it from there. So that's the short answer on it. So --

DR. VELMA MCBRIDE MURRY: So no -- so no efforts for tracking for these things?

MS. INGRID DONATO: There are certain -- there are different ways the activities are being tracked. If you go to the Web site that Sharon had mentioned previously, you will see that there is a map, and you can click on your State and community and see the activities that are happening within those communities. And there will be -- there's rolling information. So as more activities occur, they're populated within that map. So tracking definitely.

DR. VELMA MCBRIDE MURRY: Yes.

MS. INGRID DONATO: Evaluation, explicit evaluation -- impact, et cetera -- is a little more unclear.

DR. VELMA MCBRIDE MURRY: Okay.

DR. JEAN CAMPBELL: You know, that is really a shame because years ago, the -- when I was going to the APHA, they would talk about how there could potentially be negative effects when you do public announcements and how these spiked a dialogue, and it would be interesting to find out if stigmatizing attitudes are -- you would think would be decreased, but they could potentially increase as well when just the topic is brought up.

MS. INGRID DONATO: We couldn't agree with you more. And it was really a very important discussion early on, and we're hoping that that will be in the responsibility of the communities.

The funding for this initiative is zero practically --

MR. BRIAN ALTMAN: It is zero.

MS. INGRID DONATO: So we really have -- it is zero, yes. So to do that type of evaluation is incredibly interesting and useful and incredibly expensive. So we really just didn't have the resources to be able to do it.

DR. JEAN CAMPBELL: I figured it might have been a funding decision.

MS. INGRID DONATO: Yeah, yeah.

DR. VELMA MCBRIDE MURRY: Any guidance to the communities at all about how to think about determining whether or not their -- their efforts are impactful, or is it just you take this and we have the guidelines and --

MS. INGRID DONATO: Sure. Yeah, it's really the community conversations, the toolkit, the guidance is to help start the conversation, to give thought. I believe there are elements of how to evaluate your own work and encouragement about that --

DR. VELMA MCBRIDE MURRY: Great.

MS. INGRID DONATO: -- within that. But as far as funding it, et cetera, that's really in the hands of the community.

DR. VELMA MCBRIDE MURRY: That's great.

DR. JEAN CAMPBELL: You know, Missouri has done a statewide -- through the Missouri Institute of Mental Health, a statewide survey of stigmatizing attitudes and has a tool, and they just replicated it for the second time and presented -- they just presented the results. So that potentially could be something that could be made available if you're collecting, which wouldn't cost anything. But if you were collecting tools that could do that, that you could offer on a list of tools.

DR. VELMA MCBRIDE MURRY: As a resource.

MS. INGRID DONATO: And there is the Web site there to support and organize the activities, and that would be -- if they aren't there already, which they may be. This has been a very fast-moving initiative. That would be an excellent suggestion to populate that as well. And we do have MentalHealth.gov, which was launched at the same time, and we may be able to figure out ways of promoting those sorts of tools across both of those Web sites.

DR. VELMA MCBRIDE MURRY: I would like to say this is -- this is wonderful, and I commend them.

MS. INGRID DONATO: Yeah, and this was an incredibly rapid turnaround. So I think this was the fastest we've ever gotten something like this out. Wendie

Veloz, who spearheaded it, really did an amazing job. So I'll make sure to send kudos for that.

DR. JEAN CAMPBELL: So if I wanted to send the information to you, would that be --

MS. INGRID DONATO: Absolutely.

DR. JEAN CAMPBELL: Could I have your card, or are you listed in here?

MS. INGRID DONATO: I am not, but I could certainly run up and get you a card.

[Laughter.]

DR. JEAN CAMPBELL: Well, you don't have to run.

[Laughter.]

MS. INGRID DONATO: I'll saunter down later on, but yeah --

DR. JEAN CAMPBELL: Just to make sure, I couldn't go on the --

MS. INGRID DONATO: I was hoping I may have had one sneaked in a pocket, but I don't.

DR. JEAN CAMPBELL: But I would like to just share that tool because public surveying, there isn't a lot of instruments out there. And particularly those that have been replicated. So --

MS. INGRID DONATO: Absolutely. Great. That would be really terrific. Great.

MS. SHARON AMATETTI: Yeah, thank you, Jean. And you can always send anything to Nadine or myself as well, and we'll get it to the right person.

And so, just to repeat those Web sites, it's MentalHealth.gov is one of them. And the other one is CreatingCommunitySolutions -- all one word -- dot-org.

Anybody else have anything that they wanted to comment on about the announcements?

[No response.]

MS. SHARON AMATETTI: If not, we will gladly hear your updates. I thought we could just whoever wants to start can start. Who would like to start with their updates?

Agenda Item: Updates from ACWS Members

DR. JEAN CAMPBELL: Okay. I'll start. I've been blabbering along here.

I just read from the minutes what I said last time, and it's still all true.

[Laughter.]

MS. SHARON AMATETTI: It was 4 short months ago we met.

DR. JEAN CAMPBELL: Yes. I was thinking that my -- SAMHSA's past --

MS. SHARON AMATETTI: And if you could state your name for the --

DR. JEAN CAMPBELL: Jean Campbell.

MS. SHARON AMATETTI: Thank you.

DR. JEAN CAMPBELL: And I was thinking that for myself and for SAMHSA in many ways, the past is our future because I just was saying this morning that one thing I've discovered, and it's a good time to retire, is that it seems like I'm fighting battles that -- and saying things that were true 20 years ago. And I'm just tired of doing that.

I actually sent Pam Hyde a piece I wrote about the conception of violence and mental illness that I think was published 18 years ago that fit right with what our dialogue was, but the issue of promoting wellness and well-being is another topic still trying to make that issue when I looked at the framework. It sometimes is discouraging.

So, anyway, I decided in my retirement to shift, and I've been involved in an effort to integrate science and art. And working in collaboration with -- at the Missouri Institute of Mental Health, we now have a Director of Communications, and she's also an artistic director. And we formed this collaboration, and I'm now working with the regional art commission and did a performance that included -- it was called -- they had a conference called Off the Charts, and it was the integration of data and art. So they're taking this on as an initiative with the Missouri Institute of Mental Health.

And I did this performance as part of that conference, integrating the data from -- well, I contended I was the integration of art and science, to begin with, because I think we're all the embodiment of our lived experience and that integration begins within the self. But in the conference, they saw it more functional that art would be integrated into our scientific representation, and I would say also to think more creatively. And then for artists, that they would use data to inform the

content of their art.

So I did this performance and shared with them the results of the well-being project, along with paintings and poetry and testimony as an example of that. And we're going to take it another step. In the Mental Illness Awareness Week coming up in October, MIMH is going to offer a 1-day conference, and in that, we're going to combine a community partner, a researcher, and a community artist together to develop projects and then see about getting them funded within the community.

So it actually is something that I look forward to getting up in the morning and doing and thinking about, and it's fun. So I think I've found a new niche to continue on both in my creative endeavors and within the field of mental health.

MS. SHARON AMATETTI: It sounds really interesting. Is there any particular focus on women's issues, per se, or is that incorporated --

DR. JEAN CAMPBELL: Well, it's always good to come here because it reminds me that as a woman, that these issues are important. But you know, it's really hard to think about women's issues right now because it's so discouraging. I was going to bring this up later, but I wanted to know if the closure of the abortion clinics, you know, and the closing down of Planned Parenthood, which really reduces women's access and just the hostility toward -- you know, like I think of Our Bodies, Our Selves, you know, just that whole philosophy is under attack.

That it's really hard not -- when you take an artistic perspective, there is a -- there is a certain proactivity and positiveness that tries to emanate, and I -- I just am very upset with where women are. And I hope that at the ballot box that we can regain some of that power. But now you know that with the new legislation by the States to restrict even voting --

DR. VELMA MCBRIDE MURRY: Voting, yeah.

DR. JEAN CAMPBELL: -- and the gerrymandering, I think that women's issues is going to have to take more of an activist role, as opposed to some of the more soft approaches.

MS. SHARON AMATETTI: It will be interesting to see how you express that through your performance art.

DR. JEAN CAMPBELL: Yes. Well, I'm glad you planted that idea because it will germinate, and we'll see where we can go with that.

MS. SHARON AMATETTI: Thanks, Jean.

Who's next?

DR. VELMA MCBRIDE MURRY: I will respond because I wanted to commend Jean -- this is Velma McBride Murry -- on bringing up these issues because it is a trying time. It will make you wonder exactly what era we are currently living in.

Much of what I said before is also the same. Two new projects that I'd like to share with the group. I'm currently involved with a group of researchers at University of Chicago and DePaul, where we're developing a preventive intervention program that's focused on addressing issues of depression among inner-city African-American girls through a program that focuses on -- it's a mother-daughter program.

And it's designed to enhance this relationship between the mother and her daughter, and it's also designed to empower the mother and the daughter to seek what these individuals are calling protective settings in these inner-city areas. And the communities that are being targeted are those where there is real high crime in the Chicago area, and these girls are at great risk for lots of -- lots of things happening to them.

So we're starting with 10- through 13-year-old girls, recruiting them from some of our very economically depressed school districts in Chicago with the intent of having the sustainability of the program being embedded in churches and in schools. So it's some real exciting pilot data that we have been able to discover, and actually, I'm flying -- I flew here yesterday from a meeting there, a 2-day meeting there.

So it's really exciting. Thinking of ways of strengthening these families, these girls and their moms in the context of really dealing with some serious violence and lots of other high crime-related issues in the context of raising these girls.

The other issue that I've become increasingly interested in, and it's because of what I'm discovering with my work in rural communities with rural youth, is the increased incidence of HIV/AIDS diagnosis among the mothers. And it's discovered oft time when we're collecting data about their parenting their children.

And so, what I've become more interested in is the increased use of substance among these moms as a way of managing and coping with this new diagnosis, and the emergence of alcohol and substance use among rural women is really an -- it's a much more new phenomenon because of this infiltration of religion in association with how they think about managing their lives. And the silent use of alcohol and substance is becoming a way of them dealing with managing HIV/AIDS and in a community where it's hard to even talk about the fact that you have it or to seek services.

So I want to be able to study these women much more intensely, rather than just

their children, and then offering ways to think about intervention services. And they address that real urgent, silent need that's happening in these rural communities.

MS. SHARON AMATETTI: Excellent. Thank you.

Starleen?

MS. STARLEEN SCOTT ROBBINS: Starleen Scott Robbins. And Jean, before you came in, Shelly and I were actually talking about some of the changes that have happened in North Carolina over the last couple of weeks.

DR. JEAN CAMPBELL: Exactly.

FEMALE SPEAKER: In Tennessee.

MS. HARRIET C. FORMAN: And Wisconsin.

MS. STARLEEN SCOTT ROBBINS: And with the voter ID law that was just passed yesterday, it certainly will be a challenge to ensure that women find, develop, and maintain if they have a voice around some of these issues. We also had a law passed around abortion clinics and having to maintain basically outpatient surgical regulations, which will impact the number of abortion clinics that will be able to maintain their doors being open in North Carolina.

So, certainly, it does feel that we're going to have to have a different way of approaching women and supporting their access to healthcare in light of those changes. It's been interesting to watch as North Carolina and the people of North Carolina have two very differing views. We've had "moral Mondays" for 12 weeks throughout this, and folks have --

DR. VELMA MCBRIDE MURRY: They have what?

MS. STARLEEN SCOTT ROBBINS: What they call "moral Mondays," where folks have come out and talked about how they feel about the changes that were occurring. So I think -- but we also have a camp who is very supportive of the changes that have been made, and I think, you know, there is finding that balance and kind of our role in ensuring that women have the kind of support they need, regardless of where they sit, to access services.

I'm here also as a representative of the Women's Services Network for the National Association of State Alcohol and Drug Abuse Directors, and we recently had our annual meeting in June. And I am now the immediate past president of the Women's Services Network after being vice president for 1 year and president for 3 years, and I am very grateful to that group.

I was honored with receiving the Women's Services Network Leadership Award at that meeting and am very -- feel very blessed to be a part of that network because it is a network that you will hear a little bit more about this afternoon when Sarah and I do the presentation on the Women's Services Network. But it is one of the many supports that I have as a women's services coordinator for North Carolina, and I think that we have a real opportunity to learn from each other as we -- each of the States kind of goes through their different iterations of what -- what is supported, what is not supported, and how we can learn from each other and get support from each other.

The Women's Services Network is in the process of developing goals for the coming year, which I'll talk about this afternoon also, and I am grateful to be a part of this committee because it does certainly lend the support that I think we all need as we kind of fight our fights in our, you know, respective areas.

So thank you.

MS. SHARON AMATETTI: Thank you, Starleen.

Harriet?

MS. HARRIET C. FORMAN: Harriet Forman. I want to say just how impressed, how pleased I am to be on this committee and how inspired I've been by my colleagues on the committee and the work that each person is doing, both in the field and here at SAMHSA. I have really been impressed with each one of you. So I want to thank you.

While I live in Santa Fe, New Mexico, I spend the summers in Wisconsin. And I have been shocked and horrified at the political climate in Wisconsin. My friends in Chicago, I'm sure, follow the horrible things that are going on there. And thank God for the court system right now, which is holding up some of the anti-abortion legislation that has come down from our terrible Governor.

But I'm also watching what's going on in New Mexico, where the Governor has -- I imagine maybe you have seen some of this out there -- the Governor has taken away -- has closed down providers in New Mexico and brought in somebody from -- a system from Arizona to take over the mental health providers, saying that the providers in New Mexico have been fraudulently taking money from the State. And so, there's all sorts of turmoil going on there, and it's --

DR. JEAN CAMPBELL: Does that affect the block grant funding?

MS. HARRIET C. FORMAN: I'm not sure. I'm not -- you know, this is not my field. I don't really know. But I'm -- you know, this is a Republican Governor who is doing things that are extremely disturbing to people in the field. And so, the ways that politics are entering what seem to be kind of sacred ground,

intervening in the delivery of services, is very frightening.

And coming back, Jean, to the battles that -- you know, that we thought we had resolved years ago, at my -- at my grandson's school the other night, a meet-and-greet, there was still the boys against the girls, you know, the sexist -- the sexism. They had the battles, you know? They're just renewed. It's just -- it was just astounding to me. And the battles that don't get solved with each generation, it's just so clear that we have to fight these battles anew. Our jobs will never be done.

Personally, I find myself engaged in my retirement in all the political battles that we're fighting, both for marriage equality and for the sexism that we fight for women's health issues, and so I find myself involved in that on a daily basis more through the political activities that I get myself involved in. That's what -- that's what keeps my juices flowing.

Thank you.

MS. SHARON AMATETTI: Thank you, Harriet.

REPORTER: Can everybody please keep your voices up? Thank you.

MS. SHARON AMATETTI: Who's next?

MS. JOHANNA BERGAN: Johanna Bergan. So I'll repeat the wheel. My update 4 months ago sounds pretty spot on.

So I currently support chapters of young people across the country working with Youth MOVE National, and we now have 68 chapters. That's a change from last time. So I'm pretty busy trying to support groups ranging from 12 young people to hundreds of young people across States, depending on how organized they are across the country.

But despite lots of ferrying of information between them and connecting and creating a community, we do have some larger projects that have emerged over the summer months, which are exciting. One of our primary focuses isn't my specialty, but I'd like to share what my coworkers are doing. We're working to create peer-to-peer national standards specifically for young people, and that's very interesting as just the identification of what a young person is varies in every community, every system, and every State. So we're being really all-encompassing in that effort.

But there is a national commission who have worked and created a set of draft standards that are open for public comment, and we're targeting States that have some sort of youth peer-to-peer services happening. Occasionally Medicaid billable. So that's exciting. And the support material is being drafted that will

eventually be released with that draft standard. But the standards include half for those giving services and half for those receiving services. So that's exciting.

One of the projects that I'm working very closely on is hearing and creating a conversation amongst young people about the language that we use, and this conversation for me started at our last advisory council meeting. We talked quite a bit about the use or lack of the use of the word "stigma," which sparked lots of good conversation kind of back at our offices. But there are many programs federally funded that have intentionally chosen words, probably most familiar the use of the word "transition age youth," which is great, and I use it all the time. But the reaction to that word is varying depending on the community I am in.

So, in California, the young people are proud to be TAY, and they are TAY, or T-A-Y, transition age youth. Like, they want it on their T-shirts. And I can go into another community, and the young people are like "call me anything but that."

So we have held the first of many national calls where young people call in, and we limit it to 25 young people. We do a chat messaging and a verbal, depending on how young people are comfortable sharing with us. And then we have a facilitation guide that we've offered to our 68 chapters to ask the same questions in their community, and we are feeling out certain words and if young people want to be called that or not.

And if they have definitions, how did they create those definitions? Were they system mandated, or did young people sit around and say this is the age that a young person should be. This is what we'd like to be called.

Now we have a young person from Mississippi who is facilitating these calls for us. So it's gone really amazing to, like, listen to young people. So that's my -- that's my motivation project, going on and trying not to let it take up too much time. And sometime this fall, we'll have some sort of compilation of here's -- here's what we've heard over many weeks.

I'm also coordinating a group called the National Young Leaders Network, and they are young people between the ages of 14 and 29 who have been identified by a community person as a leader on the local level who is ready to have their voice heard in some greater manner. And so, I help them take their local -- usually statewide -- framework and help them see how that is different when we talk about nationally what is our work. And then taking their voice and expertise and trying to share it.

And so, these young people are offered opportunities to review documents before we would share. They sit on advisory committees for us. And then also when other organizations ask for some youth input, I have a group of young people. So right now there are 14, and it's an ever-growing number. So I like doing that.

And in the coming months, we're hearing an ever-increasing urgency to talk about mental health, which is one of our primary focuses to talk about in the context of health and wellness for the whole person. And we know that in our hearts, but it feels really good to hear it coming to us repeatedly. So, yes, young people are -- I'm feeling that young people are more outspoken that, yes, we might have a mental health diagnosis or are in recovery for substance abuse, but we -- that is one part of our person, and can we talk about ourselves as a whole person?

Thank you very much.

So that's great, and we'll see that if only, you know, in little ways as we work. When we attend conferences, our -- we're often invited to be a young person perspective. "Could you advise us on our youth track? Could you advise us on our --?" That's great.

So on a little measure, we are insisting that health as a whole is part of the conversation rather than whatever target, focus that 3-day might have, can we make sure we address our young people in all the ways that they need to be served.

MS. SHARON AMATETTI: That's great. Sounds like you're echoing some of Jean's interests.

MS. JOHANNA BERGAN: Yes. Yes.

DR. JEAN CAMPBELL: And I was going to compliment you, if you probably notice how many times she said "young person," "young people," "in recovery from," and I'm thinking that you are the change that you want to create by doing that. And you should be really complimented. I mean, it was just sterling how you used the language in your presentation.

MS. JOHANNA BERGAN: Thank you. I -- this is a great room to talk about it in.

[Laughter.]

MS. JOHANNA BERGAN: When you come into a new community, you don't know where they are in their understanding of language, and I think language is indicative of our understanding of the kind of state of our Nation as a whole.

So, and I -- you talk about schools all the time. My children are now in school, and it's kids. They're all kids. And I have been trained that you don't say "kid." And so, I'm always talking in my emails "youth" and "young people." And so, it's good to be in a familiar, comfortable setting.

MS. SHARON AMATETTI: Let me just ask you the same question.

MS. JOHANNA BERGAN: Yes.

MS. SHARON AMATETTI: Are you doing any of your work through a gendered lens, this kind of stuff, and does that come up?

MS. JOHANNA BERGAN: Well, I mean, how could I not? So I think it comes up specifically when we talk about young parents. But other than that, it's not. And I -- I didn't talk about this, but I will talk about this now.

We just -- I've been on vacation. It was beautiful. So 1 week ago, when I wasn't on vacation, I ended my week with we have four chapters in Florida, and we -- we brought everyone together to discuss the case results of the Trayvon Martin hearing. And that was a time when I thought we were going to be talking about young males. And I was, like, I am a white girl from Iowa, and I'm going to get on the phone call, and I'm going to help facilitate, and I have nothing to say.

And it wasn't. And so, I find more often that our conversations are gender neutral, even when I expect them not to be.

FEMALE SPEAKER: That's interesting.

MS. JOHANNA BERGAN: Yeah. So --

MS. HARRIET C. FORMAN: Johanna? Harriet. How many of your young leaders are young women?

MS. JOHANNA BERGAN: Lots. Yes. Yeah?

DR. SHELLY F. GREENFIELD: Can I just -- can I just say one thing about that, which maybe we'll touch on like later at the end of the day, which was just like some of the --

DR. VELMA MCBRIDE MURRY: Could you talk louder?

DR. SHELLY F. GREENFIELD: I'm sorry. This is Shelly Greenfield.

Some of the qualitative work that we've seen looking at groups of -- all women's groups versus mixed-gender groups is that it is harder for women especially, and now we're going to also look at men, to talk about gender-related issues in mixed-gender groups.

And in fact, often it's in the single-gender setting that I'll speak about women because that's what we focused on, that women are able to actually bring up with -- very rapidly and with great comfort a lot of the gender-related issues that

inform whatever the issue is or the topic is. In this case, what we've been looking at is addiction.

And that in mixed-gender settings actually believe that perhaps people can get to that place, but that the length of time it would take for trust to build for people to be able to discuss is actually very long, and most of our groups take place in very short periods of time. And single-gender settings, actually for women in particular, allow for that conversation and discussion. We're actually going to start to look at that in men, actually, in the coming months.

So I just wanted to mention that --

MS. JOHANNA BERGAN: Yeah.

DR. SHELLY F. GREENFIELD: -- because it may be that it's not as surprising as you think.

MS. JOHANNA BERGAN: Okay.

DR. SHELLY F. GREENFIELD: So just something for you to keep in mind. But I find it very interesting.

MS. JOHANNA BERGAN: Yeah.

MS. SHARON AMATETTI: Shelly, do you want to go ahead?

DR. SHELLY F. GREENFIELD: Oh, sure. I may as well.

[Laughter.]

DR. SHELLY F. GREENFIELD: This is Shelly Greenfield, and I am an addiction psychiatrist at McLean Hospital at Harvard Medical School. And I just also want to say I'm very pleased to be able to be part of this committee and find it very -- really informative and impressive to hear about the kinds of endeavors that are going on around the country by my colleagues.

I also wanted to second what Velma and Jean said about concern over the -- what seems to be the rapid incursion on women's reproductive rights in the sense that it's hard to completely grasp how we can back away from medical and public health issues that it felt like we had made major advances in. And I do think that those have major implications on the physical and mental health side of people's overarching, long-term well-being.

So I think that that's a key issue. I'm not exactly sure that I understand how the -- how that is going to be managed from a population perspective. But I think it's a very, very concerning development, and it seems to be moving very rapidly, I

think, from a medical one to a public health standpoint in the wrong direction for women's health.

In my own work, just similarly, in 4 months not that much has changed. I continue to be working in a variety of research-related endeavors on evidence-based treatments for women and addiction. In particular, you'll hear later in the day we are concluding a study on the Women's Recovery Group, which is a single-gender and gender-responsive group treatment for -- for women that can be rolled out in a variety of settings -- outpatient settings, residential settings, community-based settings -- both in a closed group format and also in a rolling group format. And I'll present that later in the day. So I won't say that much more about that.

But also I mentioned the last time that at McLean Hospital we have a variety of specific treatment programs that focus on women and girls with specific disorders, and we have -- I've been directing for 2 years an initiative called the Women's Mental Health Initiative. We are about to launch a division where we will provide an infrastructure so that these programs, which is about seven or eight in total, will be able -- a possibility to coordinate across programs with the idea in mind that we could have more clinical services, research, and training that will help integrate for the multiple co-occurring disorders that women often have.

So we have treatments that are individually set up for PTSD, borderline disorder, eating disorders, and addiction services through the life span. But we're interested in how we can better deliver those services in an integrated manner.

And in other research arenas, I continue to chair the Gender Special Interest Group for the National Institute on Drug Abuse. This is Clinical Trials Network, and we have a variety of projects through that network. They're clinical trials, and they address many different areas, including alcohol, drug, and HIV-related disorders. And we continue to try to propose both design elements and analysis elements that will be focused on gender-related issues within the NIDA Clinical Trials Network.

And then I guess I would just say I remain concerned about many of the things that we talked about on the last council meeting, including some of these emerging problems in populations of women, including the binge drinking problem that was highlighted last time, which I think it's just a, you know, very significant public health issue for women across the country. I still think it is not actually receiving the same -- the full amount of attention that it requires, given that it often occurs through young through mid life as the most important years and has a lot of consequences for mental health, for potentially sexual violence and other areas.

So I remain very concerned about that, and I think we talked about the generally

closing gender gap in terms of the increasing prevalence of all of these substances uses and disorders and that we've seen this in younger-aged girls. And in some instances, the population prevalence is exactly one-to-one in the younger ages. You know, we're looking at 12 to 16, which, actually, given the physical vulnerabilities for girls and women, has really, I think, very important and worrisome potential future adverse consequences in our medical arena and our mental health arena.

And then, finally, I'm very interested in the integration of this into primary care and other settings as we move into the next phase, and we are actually trying to do a variety of things in my own environment to think about systems -- how shall I say this? User-friendly ways that we can integrate screening, brief interventions, things that will basically enhance, hopefully, patient outcomes without being incredibly burdensome on an already very burdened group of clinicians.

So it's one area that we're very interested in, and I think much more attention needs to be paid toward this or we will have a very hard time maintaining a well population for both men and for women. So those are my areas of interest.

MS. SHARON AMATETTI: Great. Thank you very much.

Vince?

DR. VINCENT J. FELITTI: I'm Vincent Felitti. I'll pick up on the area that you just mentioned. I assume I'm here on this committee because of my role as co-principal investigator of the Adverse Childhood Experiences study.

For those who are not familiar with it, the ACE study involved 17,000 adults, matching their current health status, economic well-being, biomedical well-being, social function or malfunction, against 10 categories of adverse childhood experience, roughly a half century earlier. The relationship turns out to be extraordinarily powerful.

The study has attracted intense intellectual interest here, Canada, and northern Europe. It's also attracted great resistance to integrating any of what we learned into clinical practice, although it is moving into public health. But that's a totally separate issue.

About 10 years ago, seeing the resistance to using it in clinical practice, I was at least controlling one department that had a high volume throughput where we were seeing over 50,000 adults a year for comprehensive medical evaluation in one setting. And so, we integrated these trauma-oriented questions into the general medical questionnaire that we were using, and a couple of years later, an outside group in the data mining business came and did a 125,000 patient study for us of what effects, if any, the integration of trauma-oriented questions

into a general medical questionnaire filled out at home -- this is a very extensive questionnaire -- what effect that had.

To our absolute amazement and pleasure, they demonstrated -- and embarrassment that we didn't think of doing this. They found that this coincided with a 35 percent reduction in doctor office visits in the subsequent year and an 11 percent reduction in emergency room visits in the subsequent year. Obviously of enormous economic consequence, apart from any other attributions.

Two years later, this all disappeared. And when we looked in the unified medical records that we have, we saw that it was pretty clear that the reason for that was no one will touch that information with a pole. So the resistance to using this, in spite of the extraordinary benefit, is quite remarkable.

As a result of that, I have begun several months ago working on the development of what we're calling the North American Health Index, a probably uniquely comprehensive medical history questionnaire to be put on the Internet. And the hope is that if we develop this properly and if several million people use it -- it will probably be free over the course of a couple of years -- we'll essentially flood the primary care market with in-depth, in-breadth, remarkably comprehensive medical history questionnaires printed out, you know, not the questionnaire, but a text-based output.

And the experiment is whether repetitively provided this information, some meaningful portion of primary care physicians will begin to see the value of working with this information routinely at the onset of care. If so, that will be a major advance in primary medical care.

And underlying all of this is the fact that there are only three sources of diagnostic information in all of medicine -- patient history, physical examination, and laboratory studies. And whereas patients routinely assume the diagnosis derives from laboratory studies, if you speak with experienced physicians, they'll tell you that about 75 percent of the time, diagnosis derives from patient history.

So if this works, and I have -- I have serious hopes for it, I think it will move us into a -- into a different realm by routinely accessing realms of information that ordinarily are closed because of time, because of shame, because of secrecy, and because of social taboos against exploring certain areas of human experience. It's very clear to us -- having done this on enormous number of patients now, it's very clear to us, A, that this is acceptable to patients; B, that the amount of information that one can get if one seeks it initially by a well-devised inert mechanism like a paper-based or a computer-based questionnaire, which is then followed up in face-to-face discussions, that brings one to a different starting point in everyday clinical practice.

MS. SHARON AMATETTI: Well, it is really encouraging to see how people have become increasingly aware of the ACE study and the work. We know that adoption of practice takes a really long time, and it's -- but it's moving in the right direction.

I also -- I just wanted to bring up a point that you actually have brought to Kana's attention about the possibility of doing more with the early and periodic screening diagnostic and treatment Medicaid program that has been in place to do early screening in childhood for a number of different conditions. But, so you had mentioned that to her in a communication to the center, and also just wanted to, I guess, make the committee aware that there has been a number of different communications in terms of letters and guidance to the field that has been coming out recently from CMS and from SAMHSA and actually from ACYF as well about the need for enhanced screening for trauma and mental health issues in childhood. And a joint letter to State directors came out from SAMHSA and ACF and CMS that talks about the ACE study in the context of screening for childhood adverse experiences.

So I think that's very positive also that the agencies are recognizing the work in this context as well and that there has been some recent activity this past spring and summer to really communicate broadly about enhanced need for using those monies for this type of screening.

DR. CAROLE WARSHAW: You know, I was just going to say when you think about taking 15 years to reach that level and to thinking about having a long view of what it takes to create change, and that -- I mean, that with enough effort and will, it actually is now part of, you know, the Federal policy.

MS. SHARON AMATETTI: Right.

DR. VINCENT J. FELITTI: I simply really would like to see something happen while I'm still alive.

[Laughter.]

[Crosstalk.]

DR. CAROLE WARSHAW: It's a lot like fighting backlash, while you're trying to move forward. But really --

MS. SHARON AMATETTI: Yes. So thank you. We can talk about that more today as well.

Carole, I think you're bringing up the rear. Please say your name for the record.

DR. CAROLE WARSHAW: Carole Warshaw, the National Center on Domestic

Violence, Trauma, and Mental Health, and I'm also really pleased to be here with all of you.

Again, a lot of the same things from last time. We talked a little bit last time about our study around the mental health and substance abuse coercion, which we hope to have a report out by the end of this fiscal year, along with tools like for substance abuse and mental health providers, someone's partner is preventing them from accessing services or forcing them to use drugs and alcohol and then undermining their attempts at recovery, how to factor that into to taking a history and doing -- and in treatment planning.

But the other piece that's been interesting is that we've also -- we did a focus group in partnership with the National Council of Juvenile and Family Court Judges, their Family Violence Division, about how judges perceive these issues in custody and dependency court hearings. And the stigma that judges still carry around if a woman has any mental health diagnosis or is using, that they're more likely to give custody to an abuser who looks like he's better put together, but -- and to try to have them think about that using may be actually part of the abuse and should be a red flag to think about the whole situation differently, or someone's mental health is more symptomatic, the chances are that her mental health is being undermined and her parenting is being undermined. So to flip all of that around and to think about tools for judges.

One of the things that was interesting was that in dependency court, they have a lot more leeway to order wrap-around services because they're thinking about removal, whereas in custody court, they don't think that way, but they could potentially do that. So there's a lot of room for work around stigma in that.

The other thing that -- Rachel White-Domain on our staff is a lawyer -- we've been looking into the Americans With Disabilities Act, and there is some case law -- I think Bazelon Center for Mental Health Law has done some work in this area. But using the ADA as a way to say a woman needs additional supports in order to be able to parent successfully. And so, just hadn't thought about that as a possibility for some potential ways to use -- provide the kind of supports that people should be getting anyway in a way that legally might be more useful to them.

So that's one of the areas. Another area, a lot of our work is around capacity building with the -- all the domestic violence coalitions and programs in the country. And there's been a big push for everything to be trauma informed and thinking about what that means in the context of ongoing domestic violence and coercion control and to build an evidence base when there's not a lot of evidence for trauma informed because it's about how you treat people and how you structure your organizations, as opposed to a trauma-specific treatment.

So we -- I think it was you heard last time we have an online special connection

on VAWnet, which is the Violence Against Women net that's part of the National Resource Center on Domestic Violence and that's partly funded by the CDC on trauma-informed DV services, has a host of material. And Andy Blanch also worked with us as a consultant on developing that.

And we also have a "train the trainer" curriculum that we're piloting and should have one more iteration out next year on capacity building for trauma-informed DV services with a whole section on what it means to be inclusive and supportive of women who are dealing with substance abuse, who have psychiatric disabilities, and who are parenting. And what we're trying to do is train people in the States to be not just trainers, but the consultants to help programs actually implement that because the issue isn't just like you learn what to do in the training, it is how do you help provide the kind of ongoing supervision that helps people integrate that?

And one of the ways we've been talking about -- one of the things that's interesting about trauma-informed work is in the mental health system, it was really a kind of liberatory movement around some of the oppressive ways that people were treated and the kind of objectifying, dehumanizing ways that people were treated in the mental health system. And on the DV side, you know, empowerment and choice and respect, all of those things were part of the philosophy. So people will say, well, what do we need this for? It's clinicalizing things that don't need to be clinicalized.

And we talk about that it's the layer of understanding that often gets in the way of actually being able to do things based on the principles that the DV movement is based on. So understanding our own reactions and other people's responses like that come up in interactions with people that then our ability to be as emotionally present, empathic, and effective.

So that requires a lot. It's a lot more labor intensive and requires ongoing support. So trying to figure out how to take things to scale in ways that are very relationship based and to build some evidence.

So what we're doing, we're in the process of piloting some trauma-informed outcome measures that programs can use to evaluate their services, and we're also working with Lisa Goodman at Boston College and Cris Sullivan at Michigan State to develop a trauma-informed services measure where programs can actually assess whether they are trauma informed and then to look at outcomes for women and children who use those programs.

And part of that is to -- the other piece of the work is to really think about what it means to do culturally relevant and culturally specific trauma-informed and trauma-specific services, and what are outcomes that are meaningful to people from diverse communities? And so, how do -- so we're also doing focus groups and promising practices interviews with mostly DV programs and with people

working with refugee and torture survivor communities about what are community-based models for addressing the effects of trauma that can be delivered in grassroots agencies that don't necessarily have access to mental health resources but also may not -- kind of traditional mental health treatment may not match philosophically where people -- what is experienced as healing for people and how to think about those together.

And part of my own thinking has been stretched a lot from my work with Gwen Packard from the National Indigenous Women's Resource Center and thinking about healing as really a much more holistic process, and that often involves community. Like when you think about if everyone has an ACE score in a community of 8 or 10, with the expanded version, then it becomes collective trauma, not just individual trauma.

Or that the historical trauma, the effects of it are still ongoing. It's not just something that happened in the past. So how do communities transform themselves, not just individuals. And particularly when people will say they're very tied to communities, and how do you do that when aspects of the community, particularly around gender, may be oppressive when other places, they're really important.

Or -- so there's a lot of things to think about how to stretch the way we think about that. And how do we do this in a way that we are learning from people's experiences and trying to develop tools that people can then measure outcomes to show that their work is effective, particularly in the kind of funding crunch?

And the other thing we're doing is we're also having a small -- starting to have conversation, a small meeting around the applicability of more complex trauma approaches for survivors who are still under siege, and how does that incorporate thinking about cultural and political historical trauma, as well as developmental trauma? And what about when trauma begins as an adult? Looking at models in people both who are survivors of torture and conflict and trying to rethink that whole nexus of work.

And then how do you measure outcomes for interventions that are more survivor defined or person defined? So that they're tailored and they change over time. And kind of looking at models like child-parent psychotherapy where it's manualized in a sense, but the clinician is really working with the child-parent diet, and they have to respond to what's going on in that moment and bringing to bear all of what they understand about development and trauma and relationships, and how do we start to look at those models and dealing with them?

MS. SHARON AMATETTI: Great. Wow.

DR. JEAN CAMPBELL: So you could think about in the war against women that

that is a conflict, and maybe we should start to think about at the community level how some of these activities are really torture. And we need to -- well, I meant it really is when you think about in conflict areas, what happens in war. I'm just thinking about some of these communities, particularly like North Carolina and is it Mississippi that there's several where there's, you know, like one women's health center in the whole State -- State now, and plus all those other legislation that's been going on at the State level is that there's a lot of community trauma right now.

I mean, I'm experiencing it myself, and I don't even need access to those services. But I can think about the people that do.

DR. SHELLY F. GREENFIELD: Just to -- thanks, Carole. I just -- I am sure that you know about this, but just in case there's no other place to mention it. There was a study that was published about 2 months ago in the New England Journal of Medicine, and it was actually the lead study. And it's very unusual for a behavioral treatment study to be published in the New England Journal of Medicine.

DR. CAROLE WARSHAW: Oh, the Congo? Yes.

DR. SHELLY F. GREENFIELD: And it's Judith Bass, who is a researcher at the Johns Hopkins School of Public Health, did a scalable group intervention for women who had been sexually assaulted, raped, et cetera, during the -- all the violence in the Congo. And so, this is a scalable group treatment that was administered to women in the Congo, utilizing health lay workers to administer the treatment, and they got great results.

And so, I'm very interested in these evidence-based kinds of treatments that are actually being delivered in a scalable way. This is pretty -- this is cost effective. These are people who are in the lay community, and this is very, as you would know, under resourced from a mental health environment.

So it's just -- I just think it's worth noting. I mean, within the last 3 months, there was a major primary article in the New England Journal of Medicine -- it's really unusual -- that reports this. And I think that, you know, around the things that we are talking about, we have a lot of areas of our country you could also view as under resourced and needing access to that type of care where you could actually train and scale.

And I think, you know, group therapies, we have a lot of interest in those because they are cost-effective ways to deliver care, and they can be manualized, taught, trained, and in this instance, that particular intervention was -- it was lay individuals who were trained to deliver the care. And they actually did achieve good outcomes.

So, I mean, I just wanted to mention it here in this group just because --

DR. CAROLE WARSHAW: No, that's great.

DR. SHELLY F. GREENFIELD: -- it's a really relevant -- and it's very encouraging to me when I see a study like that make its way into the major medical journals for attention to the medical community, which is not a typical --

DR. CAROLE WARSHAW: In fact, one of our -- part of our interest in looking at lay trauma, international lay trauma worker models has come from our work with Mary Fabri, who used to head the Kovler Center for Survivors of Torture, and our -- we've just been working together over the years. But she is also starting a clinical trial in Rwanda for youth to look because they use lay trauma workers for women who had been or were impacted by sexual assaults in Rwanda because there was no other resource for this. So it's really important to think about in this country how we can do it.

MS. SHARON AMATETTI: Those were great updates. Do you mind, Starleen, if we continue just to stay a little on track, and we can get back to that later?

It's clear that you're doing a lot of work that's very relevant to one another, and this was a really -- you might not have thought that much had happened in the last 4 months, but I thought this was a very interesting discussion. And it's good to be reminded about what you're doing and what you're concerned about.

So thank you.

We're just a teeny bit off schedule. So I want to just keep us rolling here. The next thing on our agenda was to give you a brief report about what the SAMHSA Women's Coordinating Committee has been up to since we met last. So just a few announcements from me, and then my colleague Mary Blake is going to share with you some of the work that she's been taking the lead on as well.

Agenda Item: Updates from SAMHSA's Women's Coordinating Committee

MS. SHARON AMATETTI: I also wanted to acknowledge my colleagues from that committee that are here. Linda White-Young is here. Linda, wave your hand hello.

Mary Blake behind me. Jon Dunbar here. Ruth Hurtado-Day. Sara Afayee was here. Maybe she's coming right back. So thank you to all of them for being here.

As I've said before, the SAMHSA Women's Coordinating Committee is a group of internal SAMHSA staff who get together on a monthly basis to share what we're doing to make sure that we're coordinating efforts, keeping abreast of what's going on, and help each other think, problem solve. So this past May, in conjunction with Women's Health Week, the committee sponsored a program with our advisory committee member Rosalind Wiseman, who you all met last time that we met, entitled "Navigating the New Realities of Girl World and Boy World."

So we had a really great turnout for her presentation. Over 100 people attended, which is very unusual for an in-service program. It was for SAMHSA staff as well as other Federal colleagues that we knew who might be interested. So a great turnout for that. And she really spoke about social roles in groups of adolescents and about bullying and conflict and how adults can really help with difficult situations.

She left behind these bells from when she was here. So I'm going to use these bells to reconvene us, just to evoke her presence so that we know that Rosalind was here. She's out of the country right now as well. So that was a really nice thing, and we appreciate the support of our committee member.

We are currently doing some planning around FASD Awareness Day, which is on September 9th, and Jon Dunbar is the project officer for our Center on FASD. So we're working with Jon. And one of the things that has come out of the planning was doing the spotlight that I talked about earlier about the different trimesters of alcohol use. So that's something that we're doing in conjunction with that, and there will be more activities under Jon's leadership around that day.

We are also doing a new piece of work. You know that we typically have a big, large women's conference every other year. This coming year we canceled the conference because of all of the difficulties with launching and paying and getting approval for conferences.

So we had some resources that were left on the table that we wanted to reprogram, and what we've decided to do is focus on adolescent girls. So we're planning a webinar series on adolescent girls and doing an environmental scan on that population. And we are going to be working -- our committee is going to be working to do some planning at the middle of next month about what the shape of that webinar series is going to look like.

I would really appreciate the input of this committee on what that webinar series would look like. I know a lot of you are in touch with what's going on for adolescent girls. So my thought was that after the SAMHSA committee meets and we have some recommendations from that committee, that I would have a call so that you all could hear what that group suggested and then add to it. If

that sounds like that would work for you? Appreciate your input.

So those are some things that have been going on since April, and we also are represented on a Coordinating Committee of Women's Health. So the SAMHSA Women's Coordinating Committee is just SAMHSA's staff, and the Coordinating Committee on Women's Health is throughout HHS. All the agency representatives on women's issues come together and do work and that we've been doing work over the past 2 years really now about the Affordable Care Act and what the implications are for that.

But also there's a subcommittee that's doing work around interpersonal violence and trauma, and a symposium is being planned. And Mary Blake has been taking the lead for the agency on the planning for that, and she's here to tell you a little bit about what's going on.

MS. MARY BLAKE: Great. Thank you very much.

I'm going to pass out two things for you. One of them is a background paper on this particular research symposium, and here we have a draft agenda. Do you mind if I just stand?

MS. SHARON AMATETTI: If you're comfortable. We'd be happy to give you a chair.

MS. MARY BLAKE: I'm comfortable with that.

[Laughter.]

MS. MARY BLAKE: Okay. Great. Thank you.

So -- so as a result of the administration's interest in addressing issues related to interpersonal violence, HHS has a number of activities going on to look at this issue. And this particular activity is to develop a research symposium on screening and counseling for interpersonal violence, with a particular emphasis on looking at how that can be done within primary care settings. And so -- and so, you've got this background paper that tells you kind of the impetus for the development of the research symposium, and it's to help health practitioners in developing better guidelines for them for screening for IPV and for providing them with appropriate counseling tools in terms of intervention for women who screen positive.

That said, there are a couple of key points that we really hope to accomplish with this research symposium. One is to really take a look at the body of evidence around screening. So really looking at, you know, what is the current state of evidence in terms of screening and, you know, where do we need to move forward in terms of developing a stronger evidence base for screening for

interpersonal violence, especially in the context of healthcare settings?

And not just screening for interpersonal violence, but really looking at kind of the life span issues that are very often present when interpersonal violence is present. So it's looking at violence across the life span. So -- so the screening is for interpersonal violence, but it's bringing an understanding also that when interpersonal violence is present, you should think about what are some of the precursors for that, including violence across the life span.

Second -- second basic goal is to invite researchers, practitioners, and Federal colleagues to really look at what are some of the challenges, what are some of the opportunities, and what are some of the barriers in terms of screening for interpersonal violence? So one of the things that's come up in the Planning Committee is really looking at issues around mandatory reporting.

So if a woman goes in and she's being screened for interpersonal violence, and it's determined that there's a current situation, you know, what are the doctor's requirement in terms of reporting if there are children in the home? So, you know, there are challenges and barriers around screening. There are also challenges and barriers around the screening tool. So this research symposium hopes to stimulate some really good dialogue around it and help inform HHS in terms of what should we be thinking about in terms of where to go from here on this issue of screening.

And then also the goal of the symposium is to really look at the effects of screening and counseling on health, safety, and outcomes related to social and emotional well-being. So three basic goals of the symposium.

I wanted to mention that this symposium planning has been led by three marvelous women. We have Nancy Lee, who heads up the HHS Office of Women's Health. We have Dr. Marylouise Kelley from the Administration on Children and Families, and Samia Noursi from NIH. But there has been a very broad and robust Planning Committee. I want to acknowledge my colleague Sara Afayee, who has really done tremendous work on this planning group.

And so, we're looking very much forward to this. The date for it is October 4th. It's by invitation only. So I just wanted to please don't distribute this far and wide because it is an invitation-only meeting, and it's really to help set a frame for things that HHS wants to consider going forward on this issue.

I've also supplied for you a draft agenda. It's still a working draft, although it's almost, I think, final. In other words, we feel comfortable sharing it with our Federal colleagues and so then, not for distribution, wanted to let everybody know that Howard Koh, the Assistant Secretary for Health at the Department of Health and Human Services, will be basically kicking this event off. So it's got support from the highest levels of HHS.

We have some great speakers, including Jackie Campbell, who will be the keynote -- who will provide a keynote address. And then -- and then, you know, we'll have a couple of panels of people who are going to be speaking on specific issues related to this. Then we're going to be breaking into working sessions that will be co-facilitated by a Federal representative, by a researcher representative, and by a practitioner representative.

Sharon is going to be co-facilitating one of the breakouts. But some of the issues --

MS. SHARON AMATETTI: Carole is going to be there, too.

MS. MARY BLAKE: Carole is going to be there for sure. Yeah, Carole is going to be co-facilitating one of the breakout sessions. Yes?

DR. JEAN CAMPBELL: Is it invitation only because of wanting to keep the conference small or --

MS. MARY BLAKE: It's a limited capacity issue.

DR. JEAN CAMPBELL: So have you considered direct streaming? PCORI, the Patient-Centered Outcomes Research Institute, now does direct streaming of some of its -- or I would say, actually, all of its major meetings. So I've been able to attend --

MS. MARY BLAKE: Yeah.

DR. JEAN CAMPBELL: -- from my -- in my pajamas at home these conferences. And not only that, but they also then also Tweet. So you can exchange comments and your ideas as you hear things. They don't do the breakout sessions.

MS. MARY BLAKE: Right.

DR. JEAN CAMPBELL: But they do the general sessions.

MS. MARY BLAKE: Yeah.

DR. JEAN CAMPBELL: I think this is a model that SAMHSA should follow, period.

MS. MARY BLAKE: Right.

DR. JEAN CAMPBELL: Is to direct stream these things, particularly in this case if you want to encourage researchers to develop agendas. I mean, as people

are writing grants and thinking about these things --

MS. MARY BLAKE: Yeah.

DR. JEAN CAMPBELL: -- it would be really good to be able to get this out there so people could participate electronically, which we're trying to do.

MS. MARY BLAKE: Jean, that's a wonderful comment. I'll certainly take that comment back to our Planning Committee on whether there is even the capacity to do that. It's going to be held on the NIH campus. We'll bring it back. I'm not sure that there's -- yes?

MS. SARA AFAYEE: Actually, two of the big sessions are being recorded. I'm not sure of live streaming. It's financial reasons why, you know, we can't necessarily stream live. But we are recording. So it might be available, but I'm not sure.

DR. JEAN CAMPBELL: That does -- that is helpful, but a lot of times because the live -- I meant the streaming is just so much more intimate. And if you have somebody Tweeting, you have dialogue being generated and issues being brought up. So you feel like you're part --

MS. MARY BLAKE: Yeah. You're there, yeah.

DR. JEAN CAMPBELL: Yeah.

MS. MARY BLAKE: I think it's a great point, and we'll definitely bring that -- I'll bring that back as a note from our Advisory Council on Women's Services.

DR. JEAN CAMPBELL: You might be able to talk to PCORI, too, and find out how they do it. I can't think that it would be --

MS. MARY BLAKE: How do spell PCORI?

DR. JEAN CAMPBELL: P -- well, it's P-C-O-R-I. Patient-Centered Outcomes Research Institute. And that is a new research institute with research funding through the ACA. So if you're not aware of that, it's a good place. They have a Web site.

MS. MARY BLAKE: Wonderful. Thank you, Jean.

Were there any other questions?

MS. SHARON AMATETTI: Any other questions from the committee?

[No response.]

MS. SHARON AMATETTI: Well, thank you very much, Mary.

MS. MARY BLAKE: Thanks, everybody. I'm seeing that my dialogues with you are becoming a regular thing.

MS. SHARON AMATETTI: Yeah, we like that.

MS. MARY BLAKE: So we're going to have to work on that. Thank you very much.

MS. SHARON AMATETTI: That's a good thing. Okay. Thanks very much.

So it's time for our break. And for the operator on the phone, we're going to take a 15-minute break, and we will be back here -- actually, we'll take a 12-minute break. Back at 10 of the hour, if you could. Yes, thank you.

[Break at 10:40 a.m.]
[Reconvened at 10:53 a.m.]

MS. SHARON AMATETTI: Everyone, we're going to go ahead and get back on track with our agenda. I am very happy to have my colleagues from throughout SAMHSA joining us this morning to give some information about the block grants that SAMHSA supports. We often focus on our discretionary grants, but I'm not sure the extent to which the committee realizes how much of what we are able to support is supported through block grant dollars. So -- including women's services.

So I thought it was really important for us to have a conversation with those people who are very knowledgeable about our block grants. And also we invited the Acting Director of OPPI, Anne Herron, to talk about what does she see on the horizon in terms of changes because of funding through the Affordable Care Act, and how might that change what the block grant supports.

So we have here today, we have John Campbell, who is the Chief of our Performance Partnership Grant Branch. Is that what you're called, John? And where is he?

[Laughter.]

MS. ANNE M. HERRON: I'm on it.

MS. SHARON AMATETTI: Okay. Well, anyway, John Campbell is a longtime Center for Substance Abuse Treatment employee who is very knowledgeable about the block grant, and he's in our Division of State and Community Assistance and has been managing a large staff over the years who are the

State project officers for all of the block grant-funded resources.

Deborah Baldwin is here from the Center for Mental Health Services. I note that there is actually mistake on the agenda, identifying her as from the Center for Substance Abuse Prevention. That is not correct. She is with the Center for Mental Health Services. And she's going to be talking about the mental health services block grant.

And then, as I mentioned, Anne Herron is here to also help us understand the context of the block grants.

And I think we are going to start with Deborah because John has stepped out of the room. And Josh, can you help us get their PowerPoint up?

MR. JOSH SHAPIRO: Yeah.

MS. SHARON AMATETTI: Yeah. I'm going to ask -- all of them are going to present for about 10 minutes, and then we have time, a half hour, for discussion. So if you wouldn't mind waiting until the end, and then we'll have our discussion instead of questions after each presentation. So write down your notes and questions that you might have as we go through this, and then we'll have a discussion at the end.

So welcome, Deborah. Thank you.

Agenda Item: SAMHSA Block Grants and Health Reform With a Focus on Women's Services

MS. DEBORAH BALDWIN: Hello again. My name is Deborah Baldwin, and I am one of the branch chiefs in the Division of State and Community Systems Development with the mental health block grant. And I was really looking forward to doing my presentation after John Campbell.

[Laughter.]

MS. DEBORAH BALDWIN: John is -- we certainly work very close together, but I consider him a mentor, and he's been around so long. But he knows the block grants back and forth, you know? I mean, there are occasions that he'll call me to ask something about the mental health block grant. But there are more times that I call him to ask about the statute and substance abuse. So I really was looking forward for John doing at least part of my presentation.

But in any case, I was asked to give some background on the mental health block grant. So I'm going to share some information with you. And certainly, if

there's more in-depth information that you need, I understand I only have about 10 minutes, I'll be around to answer any questions. And certainly, you can contact me at any point.

The block grant is a formula grant that's given to 59 jurisdictions and all the territories -- well, actually 6 of the territories, the Virgin Islands, Puerto Rico, and the District of Columbia. There is a mandate in the block grant that it's required to implement community-based services for individuals who have serious mental illness and children with serious emotional disturbance.

There are clear restrictions on the block grant. I know you guys have heard that it's a flexible funding source. There are some restrictions, though, for inpatient services. We can't use it for inpatient services or payments to recipients, to purchase land, construct facilities. Can't be used for matching funds, or given to grants for for-profit entities.

Some other background on the block grant, as I said, it's a fundable -- a flexible funding source, and I keep emphasizing that, too, because SAMHSA has, in the most recent past, added some more accountability to the block grant. And so, we share this information with States. For the most part, States are very compliant with understanding why States need to be reporting in a different manner for these -- these funds.

There's a requirement for planning council involvement. I know many of you have heard about those State mental health planning and advisory councils. But there is a requirement that there must be consumers and family members advising States on how mental health services are delivered across the entire system. Not just those services provided through mental health block grant dollars, but it includes the entire public mental health system.

There is also a requirement to report some data, and through the mental health block grant, SAMHSA has been collecting data on the public mental health system. And we called it the Uniform Reporting System. And that's how we collected all of our data and what's happening with the block grant dollars as well as the other dollars that States spend on mental health services.

The fiscal year 2012 budget for the mental health block grant was $459 million here, which represents approximately, as said, 1 to 2 percent of State mental health authorities budget. It really is not -- no longer 2 percent. It's more like 1 percent, and that's what our contractors will tell you. And Starleen is shaking her head here because she knows.

In terms of the block grant changing -- the change in environment here for the block grant, in fiscal year 2012, there were some new goals set by SAMHSA regarding the SAMHSA's vision, and there were some expectations that the block grant needs to focus more on providing, you know, good, solid health for

folks; safe and affordable homes; a purpose for living; and active involvement in the community. There was an expectation for increased participation of individuals in recovery, access to underserved populations -- and this population does include women -- to promote recovery and resilience in the community, and then the coordination with behavioral health and primary care. And again, the accountability issue is also an expectation for 2012. This represented a change for the mental health block grant, to some extent.

So the other things that changed was there was some administrative streamlining here within SAMHSA for the block grants. States can now submit combined plans, and I think we have about more than 30-some States that submitted combined plans for fiscal year 2012 and even more, we anticipate, for 2014 for the plans coming in September the 3rd.

Some of the funding priorities, though, for the block grant that was changed is that individuals -- SAMHSA is expecting States to focus the block grant funds on individuals without insurance or for those individuals whose services and coverage have been interrupted. Where there is no Medicaid coverage, there is an expectation that States begin to look at spending the block grant on prevention. And of course, again, accountability is always there. We're expecting States to collect some performance and outcome data.

Some of the impact of change here at SAMHSA, of course, has been the amount of cross-center collaboration. I now get to work more with John Campbell than I ever worked with before. I'm learning, as well as the staff, the project office are learning more about substance abuse than we had the opportunity of learning and getting involved with before.

There is some consolidation around technical assistance. All of our TA activities are now under one contract, and so we're getting to talk about how we can share technical assistance. And to some extent, it's sort of reducing the cost of TA needs, and there is some leveraging that we have been doing around technical assistance.

There is an increased number of integrated systems at the State level, and of course, the increased number of combined behavioral health planning council. I think most of you know that or you may not know that we actually provided some resources to help States combine their planning councils. The planning council for the mental health block grant has just been for mental health block grant funds, and SAMHSA would like to see that change.

So there is quite a bit of activity encouraging States to consider adding substance abuse advocates -- advocates to that planning council. And it is -- it's working, and we hope that, you know, in a year or so, we'll be able to provide you some more information. I've provided some data on some of the slides here about how mental health services are provided to women, and if you'd just take a

look at these. I'm not going to spend much time going through these slides.

But we have an extensive data program that is now being reconsidered here at SAMHSA. I know that most of you have heard of TEDS and the client-level data. There is an effort here at SAMHSA that mental health data be collected the same way that the TEDS data is being collected. Most of our data has been collected on an aggregate basis. So we have not been able to share the detail in the data that has been provided through TEDS. So, in another year or so, we're hoping that we'll be able to provide you some more detail.

You can see here that over half of the consumers that we served were females. I don't want to -- I won't spend much time on these, but you can see the largest group of women that were served for mental health here. Race, Hispanic and non-Hispanic, high utilization on this side with our young folks and our teenagers, and we've had some conversations about that. But then there's a drop-off here with the transition age youth.

A majority of these women were served in the community setting. The Center for Mental Health Services is very much concerned about the number of women that are in institutions. We have some technical assistance fellows that were placed into wards, homestead, and the efforts to move people from institutions into the community. And so, we know that the total number really does not reflect the number of women that are in these institutions, and we know that there are usually more women than men.

Employment status is one of the domains that we are collecting data under, and we find out that there the women served in the community settings were competitively employed at a higher rate than their male counterparts.

The third one that's involving the women were unemployed, and I know that's not a surprise to anyone. A majority of the women consumers lived in private residencies, and of course, this is the number for homeless that were counted in our data and jails and correction facilities.

Living situation, most of the women served were in private residencies and that 18.7 were individuals with serious mental illness that received evidence-based services. And for children, that figure is very, very small, 2.3 percent received evidence-based services.

And here is the list of SAMHSA-approved evidence-based services. The mental health block grant program has been collecting this data over time, and this is the percent of children receiving evidence-based services, and there are only three approved evidence-based practices for SAMHSA.

That is my presentation, and certainly if you have any questions about -- particularly about the data, don't hesitate to ask us. Dr. Olinda Gonzalez is here.

She's our guru on the URS system and can answer any specific questions that you might have about the mental health block grant data.

We are -- Olinda, would you like to say something about the client-level data initiative here at SAMHSA that might give us more detail on our populations?

REPORTER: Can you stand up and speak next to the table, please?

DR. OLINDA GONZALEZ: Well, in the past 3 years, we have added to the data collection, the State data collection -- we've added client-level reporting. And we've added the -- we would be able to do a lot better analysis with client-level reporting by SMHA, but our indicators are only about five or six measures. What is employment, living situation, number of people served, people involved in the criminal justice system, and school attendance.

So, gradually, we worked with all of the States. Last year, it was 17 States were able to report on at least 3 of the client-level measures. For 2012, 30 States have been able to report. And by this December, we hope that all of the States will be able to report on at least three or four of these client-level measures. We will have in September a data analysis, for example, by diagnosis, which we are not able to have at this time. So we're going to be able to do a lot better analysis on the 50-State report hopefully by December of 2013.

The funding for the mental health data is being moved to the Center for Behavioral Health Statistics and Quality, and right now we're in the planning stages of how we're going to be integrating the TEDS data with the mental health data. And that's going to be another evolving process, and next year will be our first year where we will attempt some level of hybrid integration and hopefully move into full integration. But as Deborah said, we have some new healthcare reform efforts, and the data integration piece is quite major as we move forward.

MS. SHARON AMATETTI: If we can hold the questions to the end, I'm just a little concerned about time. Is that okay?

DR. JEAN CAMPBELL: Okay. I'll catch her.

MS. SHARON AMATETTI: Thank you so much.

Hey, John, if you want to join us? John Campbell.

MR. JOHN J. CAMPBELL: Well, good morning, everybody. Maybe in the interest of time I might do this a little bit differently. Let me just tell you what I did. If you want to --

MR. JOSH SHAPIRO: Do you want me to pull up your slides?

MR. JOHN J. CAMPBELL: Yeah, sure. I brought sort of my own little propaganda package, and the only reason I did that is I've been asked to talk about women's services under the block grants, and that's a 30-plus year history. And since I only get 10 minutes, you know, I might whiz through some of these very quickly and also pass out some other material.

But there's never a presentation where John Campbell doesn't tell a story. So, first and foremost, let me say thank you very much for your service to us as SAMHSA employees and as a person who grew up in what I refer to as the "CIA family." Some of you might know what that term means -- Catholic, Irish, alcoholic. And my parent was in treatment many times, and then did get sober through the rooms of Alcoholics Anonymous and was sober for 22, 23 years before she passed away. And growing up in a CIA family, obviously, there's other siblings involved who are also in long-term recovery.

I'm going to talk just very briefly about the history. Back in the 1980s, we started with the alcohol, drug abuse, and mental health services block grant, and there was no requirement for women's services. And a few years after that was put in place, Congress decided we want to serve or see something about women. So they added a 5 percent set-aside. And it was 5 percent of the entire ADMS block grant. So it was 5 percent of the alcohol, drug, and mental health services.

A couple of years later, somebody said, you know, that doesn't seem to be enough. We're going to go to 10 percent, and you know, that was 10 percent of the block grant. And then in 1991, and I don't think anybody here but me has this, okay? This is a report from the General Accounting Office, which is now called the General Accountability Office, and it was about the women's set-aside. And what they did is they went out to seven States to look at how the States were obligating and expending this money.

And you have to know what the statute read at the time. It said 10 percent for services for women, parenthetical phrase, especially pregnant women and women with dependent children, closed paren. Well, the statute also said that the interpretation of the statute was vested with the States unless their interpretation was erroneous. Well, guess what? The seven States they went to see, everybody was serving women. The seven States they went to see, very few pregnant women and women with dependent children were being served.

So when they rewrote the law in 1992, they established a very explicit set-aside for services designed for pregnant women and women with dependent children, and that's what we live with today, okay? And over the course of time, they built up a substantial funding base between what the States were spending in '91 and then what they set aside in '93 relative to that, and then in '94 relative to '93.

Long story short, it's in the handout. You'll see what I mean. So we started out with a base in 1994 a little under $200 million for the States in their entirety. And

over the course of, you know, 15 or so years, that's increased by almost half. So, and the way it works is it can be any combination now at this point of a State general dollar, a block grant dollar, or a Medicaid dollar that meets the State's minimum threshold. And every State's minimum threshold is a little bit different, okay?

So just to let you know that when this statute changed, they also made it very explicit that the States no longer get to interpret what the statute meant, okay? And then they went one step further and told the Secretary that not only did you have to, you know, create this new block grant, you had to write regulations governing the block grant.

So what we did is we went to our subject matter experts within SAMHSA, Sharon and her colleagues, to say what -- what would be the gold standard? If you could have everything you wanted for women's services, what would it be? And of course, they did have a document at that time that listed out this many.

Well, we were able to only negotiate several, and they are gender-specific treatment for the women and therapeutic interventions for the children, case management, transportation, linkages to primary care, including prenatal care, linkages to pediatric care, including immunizations for the children. It's like a little package. And so, that's the minimum that every State would have to provide to women. They also have to publicize the priority that women have preference in admissions to treatment.

And so, we kind of work between the States, and in each State, there is someone that kind of wears the hat of a women's services coordinator. And at one point, they probably only wore that hat, and now they find themselves wearing multiple hats. Starleen could attest to that. So sometimes I don't -- we can't get the attention of the person as quickly as we once did because they are juggling multiple roles.

What you'll see in the PowerPoint slides is the emphasis on the set-aside requirements, and I'm just going to see if I can flip through them really quickly. So, obviously, our target populations are pregnant women and women with dependent children and intravenous drug users. These are the statutory language, not necessarily the language -- we would probably talk about injection drug users now, as opposed to intravenous. And for certain States, there is a requirement related to HIV. There is also a requirement about TB.

Think of the block grant has having been a cluster of funds that were previously administered by the institutes that they cobbled together and created this block grant and had relatively few restrictions or requirements. And then, over the years, you would see amendments to the act, okay? Wow, we need to do something about this, or we need to do something about that.

So think of the block grant as not being quite a block grant, but not yet a discretionary grant. It's kind of like a hybrid, okay? But there are 17 statutory requirements under the substance abuse block grant, where I believe there are 5 under the mental health block grant.

So if I could just quickly show you -- this is all really dry, boring stuff. You can read it at your leisure. So I just wanted to get to the -- here is the set-asides I was talking about, the 5 percent set-aside, the 10 percent set-aside, and then what it became in the early '90s. And here are the requirements that I just mentioned. Primary medical care, including referral for prenatal care. And while the women are receiving such services, child care, okay? Primary pediatric -- those same things I just talked about a few minutes ago.

And this is the priority for admissions to treatment, and this is all related to priorities. And then in the regulations I talked about, we went one step further to say any program that's serving -- you know, that receives funding from the grant would have to prioritize admissions in this order. So pregnant injecting drug user, or pregnant substance user, and injecting drug user, all others.

Now this is more about the new uniform application. We went through this process beginning for the 19 -- 2012-2013 uniform application. And what we were trying to do is start to think about what were we going to do with the States and the jurisdictions as we move towards the implementation of the Affordable Care Act. So there is a very detailed planning process described in the block grant, okay? And I'm just sort of just highlighting a couple here.

But I wanted to show you that the emphasis on women has not gone away. This is, at a minimum, there's multiple bullets here. But the ones I highlighted, women who are pregnant and have a substance use or a mental disorder, and parents with substance use or mental disorders who have dependent children. So it's still there.

Now let me also tell you that the Governor of the State or his or her designee, whether it's the secretary of a department -- it might even be somebody at a division level -- they're signing a funding agreement to the Secretary. And that explicitly requires the State and their recipients to carry out the authorization related to pregnant women and women with children. That has not gone away. Even though we may have reformatted or asked the questions in a slightly different way, the statutory requirement is still there. So it has some meat on the bone, so to speak.

DR. JEAN CAMPBELL: Is that monitored to make sure that they do what they say they're doing?

MR. JOHN J. CAMPBELL: Yes. I'll tell you a little bit about how we do that, although it's probably not on the slide. So this is just, again, part of the planning

framework. And what I wanted to tell you is, well, who do I get to talk to about the block grant? Here, as well as in the packet I've given you, there is a regional administrator, and there's a program staff officer in my office that's assigned to every State.

My project staff are required to go out and visit the State once a year. And on about a once every 3-year cycle, the States undergo a fairly comprehensive investigation, as authorized by the statute, where we go out and we look at the systems at the State level, and then we drill down and look at, well, here's what the State told us in prior year plans or reports. Here's what the State told us during our face-to-face review. Well, let's go out and see what it looks like at a provider site.

And sometimes we would say to a State, yeah, you could give us the gold standard program to visit, but why don't you let us go look at one where maybe you're having some challenges? Maybe we can be a little bit of the nudge, so to speak, as the Federal authority. So there is multiple ways that we do monitor.

I think one thing that cannot be -- these are just some of our planning partners that we deal with on a regular basis, and that's me at the end. Just the most important thing that you, as council members, and those that you regularly communicate with, there is a requirement that while the plan is being developed by the State or jurisdiction and while that plan is under review by the Federal authorities, you have an opportunity to comment on that plan, okay?

And it is probably the most powerful thing you can do or your constituencies can do is talk about or express concerns about what you may see as maybe inadequate, you know, maybe the issue that you feel that needs to be addressed. And remember, some of this law was written in 1991. So you won't see terms like "trauma-informed care" or "evidence-based practice" in the statutory language or in our authorized -- in our regulations. But you will see things related to in our generic description of minimum services is to address issues related to trauma, physical, and sexual abuse. But there just weren't those terms back then.

So, but I would say this is probably the most important thing you, as advisory council members, can do, as well as anyone that you know is to look at the plan while it's under development and while it's under review by SAMHSA. Those plans, if a State chooses to do a comprehensive, integrated mental health substance abuse plan, the receipt date is September 1, although that's a weekend. So it will be September the 3rd.

If they still choose to submit a standalone mental health plan, it would be September the 3rd, and for us, for the Substance Abuse Prevention and Treatment block grant, it would be October the -- take October the 1st. So it falls on a weekend as well. So it's the first business day in October.

And those plans typically come in, they probably start to arrive this month through, you know, the receipt date. And generally, the review is done by, in our case, a prevention project officer and their team leader, a project officer on treatment, their team leader. I'm the lucky person. I get to look at everything before it gets approved. And then eventually gets its way to grants management for authorization and, you know, a release of funds.

So that's a real, real quick, probably 12-minute discussion. What I did bring to you was a little bit more information about -- a fact sheet about the women's set-aside, a fact sheet about the block grant, the telephone directory with hyperlinks, you know, the kind of stuff somebody with a little bit of the obsessive-compulsive disorder had to put together just to feel good about themselves today.

So that's -- do you want to take over, and then we'll -- we can do questions?

MS. ANNE M. HERRON: Okay. John is teasing when he says a little obsessive-compulsive. John is a lot obsessive-compulsive.

MS. SHARON AMATETTI: And that's a good thing for SAMHSA.

MS. ANNE M. HERRON: And that's a very good thing for SAMHSA. And --

MR. JOHN J. CAMPBELL: I've outsmarted them now. They used to tell me that I sent too many attachments to an email. Once somebody showed me how to do hyperlinks, I've fixed them all.

MS. ANNE M. HERRON: It's bad. It's bad.

I have no PowerPoint. I have been personally boycotting PowerPoint, and it's lasted about a week and a half. So we're going to see how long this lasts.

My focus of this discussion is really to tell you a little bit about what we're doing with the block grant in the future and how we're using it to communicate our policies and our interests and our emphasis to the State authorities around full implementation of ACA. So really over the last 4 years, when we first started preparing for the implementation of ACA, before it was -- well, right around the time it was passed, we were using the fiscal '11-'12 block grant application to send some messages to the States about how important it is to make sure that we're going to be using the block grant in ways that are complementary to expansion of Medicaid, health insurance marketplaces, those kinds of things, and not be in competition.

Because there was certainly, and there still are, some interests in the country that think once ACA is fully implemented, we can do away with the block grant. So we've been very careful to say it has a role, just as insurance, just as

Medicaid and Medicare all have a role in providing healthcare. And what we have said from 2011 on very, very clearly to the States is that you have to use the block grant for four purposes. And Deborah mentioned them earlier.

So we talked about funding treatment and other recovery support services for people who don't have insurance or for whom their coverage doesn't cover those needed services. We talk about using the block grant for -- okay, wait. I'm looking sideways. So, for people without insurance, for services that are not covered, for primary prevention, which is not covered in insurance or Medicaid or Medicare, and then to collect performance and outcome data to look at the impact of the services that are being offered.

So one of the processes that is included in the block grant application as our communication to the States is we want them to make sure that they have a plan to assure program integrity is the kind of buzz words, that they are looking at for their providers and for themselves to make sure anybody who's eligible for insurance is receiving and accessing that insurance, that if coverage exists that it pays for the services that are offered. And it's only when those things are not present that we use the block grant.

What we found in some other States as they have undergone health reform earlier on, the Massachusetts and Vermonts, is that there is an awful lot of our clients, substance abuse and mental health clients, who either churn in and out of insurance, who never access insurance, or who just their coverage doesn't cover the kinds of services that they need. So we want to make sure we're saying this loudly to our CMS partners, to anybody, Congress, to our States, that we want to make sure people understand the block grant is filling gaps and filling holes. That it's not duplicative, and it's not covering other things. So that's one thing that is throughout the entire block grant application.

The other thing that we've been pushing very strongly through the block grant application is that we want to support the State substance abuse and mental health authorities in their role under the implementation of ACA. One of the concerns is that since Medicaid is going to be covering, health insurance marketplaces are going to be managing people's coverage and the benefit package, the question comes up, well, why do we need a State authority for substance abuse and mental health? We'll just cover it through general healthcare.

Hmm, we're very concerned about that. I'm sure you guys are concerned about that. There is assurance of access, of quality. There is an understanding of a full continuum of care that must be made in place that must be understood if we're going to be able to provide people with the kinds of services that they need to get healthy and well and stay well.

And so, we've been really encouraging and supporting the State authorities'

presence in discussions around health benefit design, in their involvement in health insurance technology -- it's HIT systems. There's a name for those resources.

MR. JOHN J. CAMPBELL: Electronic health records?

MS. ANNE M. HERRON: The center at the State that manages the EHRs in the State?

MR. JOHN J. CAMPBELL: Oh, yeah. It will come to me in a second.

MS. ANNE M. HERRON: It will come to us. We've got so many acronyms, you know? Anyway, but to make sure that they are a part of that so that behavioral health is included in the electronic health records.

We want to be sure that as ACA is implemented that somebody is monitoring whether or not people are able to get to the kinds of treatment that they need to get to. I mean, those of you who were around back in the '80s in managed care know that we had lots of our providers, mental health and substance abuse providers, who were on managed care networks. Didn't mean they necessarily ever got a referral.

So we want to make sure that people not only are participating, but the services are actually being delivered. And all of those things are included as guidance in the block grant application.

We've also got some sections in the block grant application where we're asking the States to tell us what their program integrity plan looks like, what their quality improvement plan looks like, how they're participating with their partners, CMS and HRSA and the health insurance folks whose name I cannot remember. And to tell us how is that working? Are they doing a combined plan? If they are, how are they looking at the full array of services that are necessary and identifying which of those in their State are covered by other forms of insurance?

So we're asking the State to do all of those things, and really the primary vehicle that we have done -- used for that is our block grant application. So that, let me stop so we can have some discussions. But really, that -- that's the focus that we have been taking for the future block grant applications. That's it.

Agenda Item: ACWS Discussion

MS. STARLEEN SCOTT ROBBINS: Can I just say that as a State representative also at the table, that without the set-aside requirements, that there are many States that would not have gender-responsive, family-centered

treatment. The block grant is a major funder of those services, and there is absolutely, regardless of Medicaid expansion, regardless of the exchanges, it allows States to have comprehensive continuum of care.

Because there are gaps that CMS will never fill. There are gaps that we can't fill at the State level. There are gaps that can't be filled by private funding, and this funding is essential to women's treatment in every State in the country. So I just need to say that.

The --

MR. JOHN J. CAMPBELL: Check's in the mail.

[Laughter.]

MS. STARLEEN SCOTT ROBBINS: The other is not all States chose to opt for Medicaid expansion either, being from one of those States. So the block grant plays an even more vital role to fill gaps in services. But certainly, I think that the different sources of funding that we do have available, that the block grant is still the center of funding for every single state in terms of women's treatment.

Those set-aside requirements, although the language may be dated, certainly gives every State a focus of the minimum standards that need to be in place, and we can take those and work with those in today's language around trauma-informed systems of care, et cetera. And it provides the support and guidance that we need. And also the leverage with our State legislatures, with our State governments to ensure that those services are there.

So thank you, SAMHSA.

DR. JEAN CAMPBELL: Missouri legislature is also one that opted out and is not taking the expansion Medicaid funds, and I was concerned that in the block grants, while filling the gap, that doesn't that eat into the money that's available for all the other services that are provided? Isn't the block grant money in those States being used up filling that gap in those States?

MR. JOHN J. CAMPBELL: Well, it's interesting that the block grant also has a statutory requirement that requires the State -- it is not a match requirement. It's called the maintenance of effort. So the State has to contribute a substantial amount of money. In the aggregate, the State's contribution for substance abuse, prevention, and treatment service dollars is almost one-for-one for the size of the Federal block grant.

Now it differs. We could be 90 percent of the purchasing power in one State and 22 percent of the purchasing power in another. So every State has what's called a maintenance of effort requirement. So there is a substantial contribution that

Missouri and all the other States make.

DR. JEAN CAMPBELL: So it actually costs them more money then. In addition to the money they're not taking due to the ACA, it's costing them more money by having to come up with that match.

MR. JOHN J. CAMPBELL: Well, for the expansion, yes, obviously. Because there's -- it's 100 percent money for, you know, several years.

DR. JEAN CAMPBELL: Yeah, exactly.

MR. JOHN J. CAMPBELL: But you also have to look at the history of Medicaid. Not everybody -- not every State, you know, signed up for Medicaid. I think it started in, can somebody tell me, '63, '64, '65? The last State to sign on to Medicaid was in 1982. So I think what's going to happen is that there probably will be some pressure politically in many States to probably sign on later, but I think they might -- they might miss out on, you know, the 100 percent now.

MS. ANNE M. HERRON: Let me just throw out also this is where parity comes into play and the impact of parity. The States have addressed mental health and substance abuse very differently, State by State. Some States have no Medicaid coverage for substance abuse, but do for mental health services. Others, it's much more of a comparable kind of a situation.

As we move forward and parity is required, we're going to see, I think, a different array of funding for all of the services, for behavioral health services. And part of what we've got to pay attention to is what does that look like because I don't think we know yet. Do you know?

We know States that have indicated their interest in doing some things and then making sure that services are included in their State plan under Medicaid. But not all the States have passed that yet. So just like not all the States have screening and brief intervention.

MR. JOHN J. CAMPBELL: And in Missouri's case, even though they didn't expand, they did go after the health home provision.

DR. JEAN CAMPBELL: Right.

MR. JOHN J. CAMPBELL: Under Affordable Care, they were the first one to be approved for a behavioral health health home, you know, plan amendment. So, you know, baby steps probably.

MS. SHARON AMATETTI: I certainly heard things that I didn't even know about. Was this -- did you get information that was new to most of you, other than Starleen? Yeah.

[Laughter.]

MR. JOHN J. CAMPBELL: I mean, you're going to have to pay attention. We all are going to have to pay attention to things about the health insurance marketplaces because, as you imagine in a State having multiple MCOs, managed care organizations, each one of them will have to find their own medical necessity criteria, as opposed to like a standard medical necessity criteria.

So I remember the days of when I worked in the field, and I was calling up the Medicaid authority in the State of Maryland and trying to get precertification for somebody to get admitted to the hospital. I'm thinking like, oh, if I had to call more than one, and that was in the days when they said, well, pull that up on your screen. And I'd say that's an IMB Selectric II.

[Laughter.]

MR. JOHN J. CAMPBELL: So, yes, ma'am?

DR. CAROLE WARSHAW: But don't States have to have like a minimum benefit plan for their State plans?

MR. JOHN J. CAMPBELL: Yes. Yes.

DR. CAROLE WARSHAW: And the process for influencing how mental health and substance abuse services are in them? That's totally random and up to the State to get themselves at the table? There's no Federal involvement?

MR. JOHN J. CAMPBELL: Well, Medicaid has promulgated regulations related to the essential health benefits. And I'm not very good on paraphrasing the language, but there is a requirement that the health insurance marketplaces reflect or be comparable to, what, the single largest State employer-sponsored plan, or there is some very clever language.

There's tons of information on our health reform Web site. If you go into just SAMHSA.gov, click on the health reform icon, there is incredible amounts of information there. Some of it you can probably even drill down to State-specific information.

DR. SHELLY F. GREENFIELD: Could I ask just a sort of naïve question, which is with the way in which you said historically the block grant wording was written, which at the time it was addressing women's mental health and substance abuse needs directed toward pregnant and parenting women --

MR. JOHN J. CAMPBELL: Yeah.

DR. SHELLY F. GREENFIELD: -- just to consolidate. So, with that, what happens to women's treatment needs who aren't pregnant and parenting?

MR. JOHN J. CAMPBELL: Good question. Because there's probably any number of -- we collected information on women who were served and a subset of pregnant women --

DR. SHELLY F. GREENFIELD: Yeah.

MR. JOHN J. CAMPBELL: But we don't necessarily know how many of those women served are women with dependent children. So, so as you can see from the priority admissions, the priority admission doesn't really require you to be a woman with dependent children to get admitted to treatment. It's pregnant injection, pregnant substance use. So --

MS. ANNE M. HERRON: But I think you're asking something different.

MR. JOHN J. CAMPBELL: Yeah, yeah.

MS. ANNE M. HERRON: You're saying what do we know about just services to women?

DR. SHELLY F. GREENFIELD: Yeah, that's sort of what I am saying. In other words, I mean, I'm interested in the fact that, you know, when you look through the life course and, you know, as we begin to move toward thinking, you know, about wellness and integrating behavioral health into full healthcare, you're really looking at the full life course. And women's health and women's mental health is through the entire life course and not only about the pregnant and parenting phase.

And so, I just was curious about that. I understand, and I know it was real helpful to hear the history because, obviously, at the time that that language was being inserted there was a desperate need, and it was being captured by the language in a way that was, you know, at the time very -- what's the word -- progressive or just --

MR. JOHN J. CAMPBELL: Yes.

DR. SHELLY F. GREENFIELD: But now X number of decades later and we've changed in terms of how we think about how we're delivering healthcare, I just wonder about the degree to which that language both protects certain things, but also may constrain certain things.

MR. JOHN J. CAMPBELL: Restricts it.

DR. SHELLY F. GREENFIELD: And so, that's what I was kind of curious a little bit about.

MR. JOHN J. CAMPBELL: Well, let me -- here's one general rule about block grants. If it's explicitly prescribed, obviously, the State is required to carry it out, whatever that prescriptive language is. If it is explicitly prohibited, then obviously you can't do it, okay? Well, if it's not explicitly prescribed or prohibited, then the State has the flexibility to use the dollars, you know, as they see fit.

So let me give you an example, and then I'm going to -- this is Starleen's home State. And many States collect much more data than we require them to report. We only get information, minimum information on what we call the national outcome measures, which is abstinence related to alcohol use, drug use, employment, you know, the criminal justice activity, et cetera, et cetera.

Well, I know that in the data that North Carolina was collecting, one of the outcomes that they saw among pregnant women was the number of pregnant women who reported that they use tobacco products. And you think like, you know, who would have -- you know, nobody was thinking about addressing that. But obviously, it would be something really interesting or we should be addressing it as it relates to neonatal care.

So, so any -- there's lots of things that happen as a result of these, you know, interventions for women, and some of the service models are just, they're just incredible. Chrysalis House in Kentucky started out as this little, tiny community-based organization who has been very generously supported by the community and benefactors and the like. And now it's a very comprehensive program for women. And there's ones like that all over the country.

MS. DEBORAH BALDWIN: I just want to say that I know that we're picking up a number of those women through the mental health data reporting system. But because of the way that we've been collecting our data, we aren't able to report out on the specific services that these women may have been receiving. But I am certain that a number of those women fall into the mental health system, particularly women with co-occurring disorders.

And with this new -- the integration of the TEDS data with the mental health data, we should be able to share more specific information with you in perhaps a year or so where those women are getting services.

MS. ANNE M. HERRON: Can I just throw out one other --

MR. JOHN J. CAMPBELL: Yeah, go ahead.

MS. ANNE M. HERRON: One other thing. You're having the NASADAD women's coordinators come and speak, right? Or from -- a representative

today?

MS. SHARON AMATETTI: Yes. That's Starleen.

MS. ANNE M. HERRON: I mean, one of the kind of impetus for that, Sharon, and you can speak to it much more articulately than I, was that there was so much exciting work going on in the States -- way more than what was being collected in the block grants -- about services specifically to women, that the ability to share those lessons learned and those outcomes and the impact that programs and providers were having, that was one of the reasons that group really began in the first place was to start sharing in much more than what we were having to collect in the block grant.

So I just wanted to throw that out.

MS. SHARON AMATETTI: Yeah, and also to your point, Shelly, very good and relevant point about the needs of nonpregnant, nonparenting women. But one of the wonderful things about the set-aside language is that it really raised the bar for gender-specific services for women, regardless of your pregnancy or parenting status. So that's -- that's been a really positive benefit for all women, I think.

And it's true that the Women's Services Network has worked very hard to address the needs of women across the life span. And Starleen, maybe you'll talk about that later today some, too?

MR. JOHN J. CAMPBELL: Sometimes language kind of gets in the way. And when we were writing the regulations in the early '90s, there were a few evidence-based practices related to doing outreach for HIV. So if you were to read our regulation, there is a preamble to the regulation that actually talks about those three models. But when you get into the actual regulation itself, you don't see anything explicit about those particular models.

In the statutory language, there are some additional agreements that would lend you to say, well, what does that actually mean? Well, one of them is, you know, that the States are required to improve the process for making referrals to treatment. It doesn't talk about a uniform standard clinical assessment, you know, or it doesn't talk about patient placement criteria. But that's what it's really implying, okay?

There's also another requirement that you have to coordinate all the services with health, education, voc rehab, you know, the laundry list of those, you know, ancillary services. So there's more than just the women's set-aside prescriptive language. There is other prescriptive language in the statute. So --

MS. DEBORAH BALDWIN: And John, the new application, the 2014 application

actually does go a little bit further, and I want to say they were speaking directly to mental health because there is no set-aside in the mental health block grant for uber gender-specific services or for women's services. So, but there's language there that adds women as one of the groups that we need to pay attention to with the mental health block grant.

So we are anticipating with the new applications that are coming in for 2014 on September the 3rd, we will have some idea how States have begun to identify those specific services.

MS. SHARON AMATETTI: I think we're going to tell them.

MR. JOHN J. CAMPBELL: Yeah.

MS. SHARON AMATETTI: Any last thoughts or questions? I'll go to Jean.

DR. JEAN CAMPBELL: I just wanted to know if the statutes come up for reauthorization, and if they do, would there be an opportunity to change those statutes in those areas where there is obviously real deficits?

MS. ANNE M. HERRON: Absolutely.

MR. JOHN J. CAMPBELL: Yeah. In the fact sheet that's in the folder, you'll see sort of the history of how things got amended. So there were several times that the ADMS block grant language was amended. The substance abuse prevention and treatment block grant and the community mental health services block grant, which were split from that one large block grant in 1992, there's only been one reauthorization.

But this is the mystery of the Government. You know, we were authorized initially in 1992 for 3 years. So that would have been '92, '93 for our fiscal year, '93, '94, '95. Well, we weren't reauthorized again until 2000, but we continued to operate as though we were.

DR. JEAN CAMPBELL: So is it ad hoc, the reauthorization?

MR. JOHN J. CAMPBELL: No, no. Everything just stays in place. And so, in 2000, they made some minor changes to us. They took away a requirement that was, you know, just kind of problematic. They used to split how many dollars you had to spend for alcohol prevention and treatment and drug abuse prevention and treatment. So they repealed that.

And then there was a requirement to have a loan fund, and what they did is they made that optional. So that they just turned a "shall" or a "must" to a "may," okay? But we -- and that, again, in 2000, we were reauthorized for 3 years, for 2001, '02, and '03. And here we are in 2013, and we're still going along.

There will be at some point some obviously attempt to do --

DR. JEAN CAMPBELL: Soon.

MR. JOHN J. CAMPBELL: -- SAMHSA reauthorization language again. And you just have to kind of keep your ears and eyes posted because --

DR. JEAN CAMPBELL: Gearing up for it.

MR. JOHN J. CAMPBELL: -- we could be -- we could be reauthorized and be attached to any bill, okay? Not necessarily be something specific to the Public Health Act. The last one was called the Children's Health Act of 2000, and it had a host of things in it, including, you know, some changes to the substance abuse block grant, you know, authorization. So --

MS. SHARON AMATETTI: We'll keep you apprised of what we hear about.

MR. JOHN J. CAMPBELL: Yeah. Trust me. Everybody, everybody will know. Every trade association in the world will keep you informed, and there will be lots of, obviously, hearings and things like that to inform the decision-makers. And of course, you know, lots of things happen, and it's all based on who sits on the committee at the time. So, you know --

DR. CAROLE WARSHAW: Just whether you want to bring it up or you want to keep it under the radar.

MR. JOHN J. CAMPBELL: Yeah. Yeah, sometimes you say do you want more prescriptive language, or do you want more broad language? It really depends on the issue, you know? Because sometimes the prescriptive language can also restrict you. So --

MS. SHARON AMATETTI: Deborah, John, Anne, thank you so much.

MR. JOHN J. CAMPBELL: You're welcome.

MS. SHARON AMATETTI: Really appreciate it. Very good, and this is a great segue, I think, to our after lunch discussion with -- about the Women's Services Network. And so, we have an hour now for lunch.

Do you have any announcements about lunch, or is there -- do we have lunches?

MS. NADINE BENTON: I do have all of your money for lunch, and it should be here in a few minutes. So --

MS. SHARON AMATETTI: Okay. Very good. Great. We'll reconvene at quarter of.

Thank you.

[Break at 11:49 a.m.]
[Reconvened at 12:48 p.m.]

MS. SHARON AMATETTI: We're going to reconvene if I can get everyone's attention, please? Thank you.

Before we launch into the next part of our agenda, we want to acknowledge that three of our members, this is really the end of their terms. And you all have -- some of you, most of you mentioned this morning how much you appreciated being part of this advisory committee, and I just want to say on behalf of SAMHSA, on behalf of Kana and Pam, how much we've really appreciated your service.

And so, if you'll indulge me in a little bit of pomp and circumstance right now, I would like to present some awards for service to our retiring members. Harriet Forman, would you come on down?

[Laughter.]

MS. SHARON AMATETTI: Harriet, thank you so much for your service to the advisory committee, and we want to just present to you on behalf of SAMHSA this lovely piece.

MS. HARRIET C. FORMAN: Thank you. Wow. It's lovely.

[Applause.]

MS. SHARON AMATETTI: And Harriet, we'd like to ask if you would still be available to us until your replacement is nominated and put in place through the -- through next April.

MS. HARRIET C. FORMAN: Sure.

MS. SHARON AMATETTI: That will be very helpful. So thank you very much, Harriet.

MS. HARRIET C. FORMAN: Thank you, Sharon.

MS. SHARON AMATETTI: Velma McBride Murry.

[Laughter.]

MS. SHARON AMATETTI: Thank you, Velma, for your service. So much appreciated.

[Applause.]

DR. VELMA MCBRIDE MURRY: Isn't this gorgeous?

MS. SHARON AMATETTI: We hope you will display that. And like Harriet, we'd like to ask Velma if you would be available to us through next April?

DR. VELMA MCBRIDE MURRY: I would be delighted to.

MS. SHARON AMATETTI: Thank you so much.

And Starleen Scott Robbins, come on down.

[Applause.]

MS. SHARON AMATETTI: Thank you, Starleen, so much on behalf of SAMHSA, and we're hoping that we can call on you as well through April?

MS. STARLEEN SCOTT ROBBINS: Sure.

MS. SHARON AMATETTI: Thank you very much. Congratulations.

MS. STARLEEN SCOTT ROBBINS: Thank you.

MS. SHARON AMATETTI: Thank you so much, everybody.

And with that, we're continuing to rely on Starleen right now. Starleen and Sarah Wurzburg from NASADAD are going to share with you information about the Women's Services Network, which we've talked about a lot, but we haven't gone into a lot of detail about what this network is all about and how it can -- how it has helped SAMHSA, how it helps the field. And so, we wanted to spend some time now doing that.

So, as before, we'll ask Sarah to present, Starleen to present, and then we'll have our discussion. I'll turn it over to you, Sarah.

Agenda Item: NASADAD Women's Services Network (WSN)

MS. SARAH WURZBURG: Okay. So I'm Sarah Wurzburg, and I work for the

National Association of State Alcohol and Drug Abuse Directors. And like we were talking about the block grant before, in, you know, each of the States and the territories, there's a State substance abuse agency, and those --

[Pause.]

MS. SARAH WURZBURG: Okay. Now people can hear me. And those are actually our members, the people who are responsible for that, as well as other funding. We've been around for over 30 years, and we are -- so our organization is we work with State directors and also members of the State agency staff. So we have a National Prevention Network, who are the prevention directors and leads in the States; a National Treatment Network, who are the treatment directors; and then within that, we have the Women's Services Network, which we're talking to you about, as well as the Opioid Treatment Network. And there's a State opioid treatment authority in each State.

So these are kind of with each of these groups, we work specifically with, so for the WSN, women's services coordinators in each State to provide technical assistance and to facilitate State information-sharing on topics of interest to the group.

And so, for the history part, I will definitely hand it off to Starleen, who's been here since the beginning.

MS. STARLEEN SCOTT ROBBINS: So, as John talked about earlier with the women's set-aside, the women's services coordinators started to be designated across the States. Right now, we have 46 States that are represented with a women's services coordinator who manages the women's set-aside block grant funds for their States, and we have one territory representative right now from Guam, brand new to the Women's Services Network.

CSAT had been meeting -- has been having meetings and phone calls with the women's services coordinators for several years. And in 2007, SAMHSA and CSAT and Sharon thought it was a good idea for us to actually have a dialogue under NASADAD, and we met as a group with all the women's services coordinators. We came up with some bylaws. And in 2007, we became a part of NASADAD under the National Treatment Network.

And this year, the National Treatment Network just amended their bylaws, and we are now voting members of the National Treatment Network, which is a great place for us to be. So anything that they are looking at in terms of their policies and what they do, we will have a voice and a vote at that table, which is wonderful.

The Women's Services Network is one of the networks under NASADAD, and it focuses on women's prevention, intervention, and treatment. The membership

includes -- all of the States are invited to be a part of the Women's Services Network, including the territories. And again, we have 46 States and 1 territory who are represented currently.

And the primary role of the Women's Services Network is to address the unique treatment and prevention needs of women and their families across the life span. So we're not just looking at pregnant women or women with children. We are looking at women across the life span. And one of the other roles of the women's services coordinator is to expand and improve publicly funded programs, and that is our programs that are funded by the States with their State and Federal dollars. And to facilitate collaboration with other public and privately funded service agencies, such as child welfare, health.

We have lots of partners working with families in particular. You know, there's not one agency that could support financially the kind of needs that a family has, and so we work very closely with our other State partners and sister agencies in order to provide comprehensive services.

The Women's Services Network structure includes our Executive Committee. We have four committees currently -- the Criminal Justice Committee, Outcomes Data, Pregnant and Parenting Women, and the Recovery-Oriented Systems of Care. We also have a new workgroup, which is the trauma-informed care workgroup, which we'll talk about a little bit later. And we have an annual Women's Services Network business meeting on a yearly basis, where we meet -- it's our only face-to-face meeting where we meet and we actually review our goals and our outcomes from the previous year and develop our goals for the coming year.

Our Women's Services Executive Committee is a member-elected Executive Committee. We have brand-new officers for our Women's Services Network. That includes Karen Mooney from Colorado is our new president. Suzette Tucker from Maryland is our new vice president. Our new secretary is Christine Scalise from New Jersey, and our new treasurer is Barbara "BJ" Brooks from Illinois. And I am the first immediate past president because that was just added to our bylaws. The other networks already had an immediate past president position, and now we have one as well, and I am that person.

We have also regional representatives from the 10 regions, the HHS regions, who are part of the Executive Committee. And we also have liaisons from each of the networks and from CSAT who are part of our quarterly phone calls as well, and our subcommittee chairs. Each of the officers as well acts as a liaison to one of the other networks. For example, the president of the WSN is also liaison to the National Treatment Network. So she sits on that Executive Committee and participates in their quarterly meetings.

The Criminal Justice Subcommittee is dedicated to the improvement of social

justice, support, practice in multiple systems and disciplines. And this subcommittee has done a lot of work around the criminal justice, specifically around women who are incarcerated and the types of treatment that they have access to not only within the criminal justice system, but as they're transitioning back into the community. Their goals, they've been working over the last year at looking at collaboration with the drug courts and considering how to include more gender-specific care with our drug courts across the country and also reviewing training tools and resources to educate judges, court staff, and the Administrative Office of the Court about substance use disorders.

Our Outcomes Data Committee has played a role in actually looking at the different States and the types of outcomes and data that we collect around women's treatment and seeing how those -- how that data is used and how it can be used to help support treatment and services within our States. And right now, they are actually focusing on one of the requirements of the block grant, which is around the therapeutic services for children and looking at the data that States are collecting around those therapeutic services.

And for States who aren't collecting, how they can begin collecting information around that and also at the definitions that each of the States are using to define therapeutic services for children. Because although it says therapeutic services for children in a block grant, as John said earlier, it doesn't necessarily define. It gives some examples of what that looks like but does not define it.

And then we have the Pregnant and Parenting Women's Subcommittee, and they're dedicated to the education of policymakers and legislators regarding substance use during pregnancy. And this subcommittee has done a lot of work around looking at fetal alcohol syndrome, and the focus right now is really big also around opioid dependence and pregnant women.

As you may know, the use of particularly prescription abuse has increased dramatically across the country, and so we've had a number of speakers talk about what is happening in terms of treatment and the types of supports that States are providing pregnant and parenting women around opioid dependence. And there's a big push around looking at protocols for neonatal abstinence syndrome for babies who've been exposed and actually experience withdrawal as a result of the opioid exposure during pregnancy.

Our Recovery-Oriented Systems of Care for Women is dedicated to the integration of gender-responsive prevention, early intervention, treatment, and recovery services for women and their families across the life span. And they are looking specifically at the gender-responsive services and gender-specific services within in a ROSC system. So how are States actually ensuring that when they're setting up recovery-oriented systems of care, what are the specific services that they have in place that address the needs of women?

And a few months ago, was it back in January or February?

MS. SARAH WURZBURG: In January.

MS. STARLEEN SCOTT ROBBINS: In January, Sharon actually came to us and said, you know, we have an opportunity here to start a strategic planning process. And we have actually Deb Warner from Advocates for Human Potential working with us to coordinate and moderate a strategic planning process for the Women's Services Network, first to kind of look at the things that we would like to work on as kind of a specialty project across the WSN and not necessarily specific to a specific subcommittee.

And NASADAD and Deb Warner did a survey of the WSN membership, and we had probably about 15 or 20 different areas that the WSN specifically talked about interests in, and these are kind of the top five topics. The Executive Committee and the officers had meetings and met to kind of take the top five topics and to make sure that we were actually going to be able to cover those in at least one of our subcommittees and then created a workgroup around trauma-informed systems of care, which was by far showed the most interest within the network. As a result, we have developed a trauma-informed care workgroup.

We've been having monthly topic calls or webinars and developing a plan on exactly what the membership's needs are in terms of trauma-informed care, and we've done a lot of talking about the distinction between trauma-informed services and trauma-informed organizations. And I think that most of the membership or most of the States are using some sort of trauma-informed, evidence-based practice, whether it be seeking safety or TREM or one of the other practices, but have not necessarily looked at the trauma-informed organization and the whole idea, Carole, of assessment and what that looks like for an organization to be trauma informed.

And so, we've been doing a lot of talking about looking at the different tools that are available out there. Roger Fallot and Stephanie Covington and a number of others have done some great tools that help you determine whether or not your organization is trauma informed and looking at your policies and procedures and, you know, from the time you make that first phone call to that organization to the time that you're actually receiving services.

So we're kind of still developing what we're looking at doing over the next year and what the focus will be. But what we're trying to do is make sure that for those States who have not developed some kind of system of care, that it's going to be helpful in their overall planning and implementation process.

The member services is probably one of the best functioning listservs, I think, that I'm a part of in terms of being able to facilitate communication between the women's services coordinators across the country. We have an opportunity, if

I'm, you know, in the middle of trying to figure out how to develop policy on, you know, urine testing for TANF recipients, I know I can put in an inquiry with Sarah, and she can shoot that out. And I mean, literally in minutes, I have women's services coordinators giving me their policies, their State laws, their tools, whatever it is that they have available. And so, it is an invaluable way of not having to start everything from the bottom up because there are so many good, dedicated people out there who, if they don't know something, they know somebody who knows something.

So -- so those are just some of the examples of the things that we've done through inquiries from State to State. So it is wonderful networking. It is a real opportunity for us to learn and grow together. And you know, when we get together that one time a year during our business day, I think, you know, it's kind of like old home week because we get to see each other only usually once a year. But the things that you walk away in terms of what you learn about what the other States are doing really adds some momentum to what is possible in your own State.

So every time I walk away, I feel like I have 10 or 12 new things that I can bring back to North Carolina and say we need to be looking at this, guys. This is what we can do. And we also need to get back to so-and-so in South Carolina or Virginia or wherever so that we can help them do some of the things that they're looking at doing.

One of the very first accomplishments that the women's services coordinators had as the WSN was working with NASADAD and CSAT and Children and Families Futures on the Guidance to State Treatment Standards for Women with Substance Use Disorders document. Maria Morris-Groves and myself were co-chairs of our Treatment Standards Committee, and just special thanks to Kara Mandell, who was with NASADAD at the time, who put a lot of work into the development of these guidelines, and Deb Warner. They did some amazing work.

You know, we did one of those was it 1 day or 2 days, Sharon, where we did that kind of brainstorming? I mean, and so we, like, threw up on the paper, and then they made it into this document.

[Laughter.]

MS. STARLEEN SCOTT ROBBINS: It was like magic. I love magic. And so, the Guidance to States document is wonderful because here's another example of where there have been some really good things that have been developed in the States that we were able to kind of put all into one document to be able to share amongst each other, and it can assist the States who don't have policies and procedures and what have you in place to be a guidance for implementation of different policies and standards.

And it's also an opportunity if they can't put them in place to at least have kind of prioritized the things that need to go into place. And the CSAT comprehensive substance abuse treatment model for women and their children was a great framework because it had 25 service elements, anywhere from outreach and screening to different treatment modalities -- residential, outpatient -- and all the way to recovery supports, to transportation and child care. So we had 25 elements that were defined as a part of this framework based on clinical treatment services, clinical support services, and community support services.

And so, each element was defined, each of the States that had standards around these areas were identified, and then recommendations on development of a standard if you did not have a standard in place was described in the document. And Sarah -- and we've had a number of States who have been able to utilize the Guidance to States document to actually further develop their policies and procedures or to implement, like Illinois, their gender competency endorsement.

And California actually took the Guidance to States document and made an assessment tool for their programs around each of the standard areas so that they can use it as a kind of a monitoring and technical support tool. So it's an excellent opportunity particularly for States who are trying to develop a framework from the beginning because not every State, just because they have women's treatment, has the standards in place.

The therapeutic services for children whose parents receive substance use disorder treatment document, again, was a partnership between NASADAD and CSAT/SAMHSA, and this particular study was looking at the therapeutic services for children that are the requirement through the block grant. And its mission was to define how States were defining therapeutic services, determine what services are provided, establish criteria for receiving services, and ensure that children have access.

And there were nine States who participated in a study to see exactly how they were doing all these things around therapeutic services, and the nine States are listed below. And I just want to share with you kind of the outcomes of that study.

One was that States defined therapeutic services to children through various mechanisms, through their contract language, administrative rules, licensing regulations, and therapeutic child care guidelines. So everyone kind of has a different way of describing what that looks like, and providers are encouraged to create and maintain formal and informal linkages with comprehensive resource networking including, but not limited to child welfare, child care agencies, early intervention programs, and primary care.

And this should not be a shock to anyone that the single State agencies and providers found that the care coordination and case management are key components in providing cost-effective, appropriate services for children whose parents enroll in substance abuse treatment. The single State agencies reported that services to children are typically provided through referral to other available services and by collaboration with other agencies, particularly child welfare, to leverage existing services and funding. And that fragmented systems are often -- and often conflicting the agency policies at both the State and local level can be barriers to providing therapeutic services to children.

So that was kind of the outcome of that study. And as our Data and Outcomes Subcommittee continues to look at that to help States refine what it is they're doing and how they're measuring it and how those outcomes are being utilized, we hope to get some more good information from that process.

The WSN has participated in the Planning Committee for the National Conference for Behavioral Health for Women and Girls. We participate as moderators and presenters and find it as an invaluable resource and training opportunity. We've also participated in the National Conference on Substance Abuse, Child Welfare, and the Courts and some of the other conferences there.

I'd like to personally point out the Women's Addiction Services Leadership Institute, WASLI, which the officers of the WSN have had an opportunity to participate in for the last few years. It is an extremely invaluable opportunity to learn more about yourself as a leader, but also to support others in their leadership.

I had the opportunity to be a part of WASLI as a coach, and I learned so much about myself. I learned, one, that I'm off the chart introvert.

[Laughter.]

MS. STARLEEN SCOTT ROBBINS: And -- and I work very hard and spend a lot of energy in not being an introvert every single day of my life in my professional life. So -- so that kind of helped me figure out some things.

But it is unbelievable the types of, first of all, the women who come in on the first day and 6 months later walk away with these projects that should take 2, 3, 10 years. And they accomplish these wonderful feats of accomplishments with, you know, things in their States that are going to help either support or begin or build services for women. It is absolutely incredible, and the things that they walk away with personally and the way that they talk about that growth experience is pretty incredible.

And I also kind of got a kick out of being an ASAM field reviewer, and so a number of the Women's Services Network folks were invited to be a part of the

ASAM field review for the next ASAM patient placement criteria. So we really have an opportunity to influence and be at the table and be a part of with the SAMHSA technical expert panel. We had the Core Competencies for Working with Women and Girls that I had an opportunity to be a part of, and it has -- and that document, if you have not seen it, is on the SAMHSA Web site. And it looks at from the perspective of professionals working with women and girls not just from substance abuse and mental health, but from any perspective, the types of skills and abilities that a person should have when working with women and girls.

So if you haven't seen it, go on the Web site. Usually the printed copies are like, well, they're free, but they're sold out. But you can download it. But if you get a chance, get them and hand them out to folks because that is an excellent tool.

And wow, that went quick.

[Laughter.]

MS. SARAH WURZBURG: Yeah, I guess I have two things to add. So from the guidance, the women's guidance document, we actually have been working with -- at NASADAD, we also have a State Youth Substance Abuse Coordinators Committee, and I am the lead for that as well. And I have been working on drafting a similar guidance document for the youth, and we actually just have a working draft now, which I submitted yesterday. So, yay.

And so, we have used that as the inspiration to actually try to help build the youth systems in the States as well. So that's a really exciting thing that we're working on with the youth coordinators and also, of course, the youth issue overlaps with this committee as well.

Another thing is that a lot of the things that we've done and have been possible is because we've really had a great champion in Sharon Amatetti, and we've been incredibly lucky to have the support for the WSN, as well as for NASADAD, because I think a lot of the ways that the WSN gets invited to some of these great opportunities is through Sharon. So I think that's really important that we're lucky to have her as a champion, as is this group, as is SAMHSA.

So thank you for that.

And then the third thing is one of the colleagues who works with me to help with the WSN is Kelly Zentgraf. So that's Kelly over there. That was it.

[Laughter.]

MS. SHARON AMATETTI: Your check is in the mail also.

[Laughter.]

MS. SARAH WURZBURG: That's how we get invited.

Agenda Item: ACWS Discussion

MS. SHARON AMATETTI: Thank you. Wow. So that was a very good, comprehensive overview of what's been happening and how it's developed over time.

And it really has developed over time. This didn't just all happen even in the last couple of years -- and you know, it's interesting to see how things build and fit together, and this has been just a beautiful merger of a lot of different policies and legislation and opportunities and then leadership from the women who are serving in those roles in the States, as well as the leadership at NASADAD has just come together very nicely.

So what are your thoughts? Questions for Starleen and Sarah, as well as suggestions that you might have for the WSN? I think issues that you think that they might look at, I don't know, that they might not have come to the top of their to-do list yet, or other resources that you might have for them that they could build upon? All of those things would be of great interest.

Yes?

DR. VELMA MCBRIDE MURRY: I have a comment, which is that this is just absolutely incredible. So I commend the efforts. And I'm sitting here thinking about how useful this information will be or could be or can be for training graduate students and just trying to think of ways to bridge what is being done here with academic institutions. So I'm thinking about a lot of the tools that we've talked about today. Social workers, graduate students in social behavior sciences like the American Psychological Association, which just finished developing a review paper -- well, developing a strategic plan for training psychologists in the area of trauma and women's issues.

And so, as I think about how useful this information is, it would just be wonderful if there's a way to enhance academics or academic institutions' knowledge about what's being created here because they're training a group of individuals that's going to go out into the settings to -- and they could greatly use these tools.

So I'm just sitting here saying, wow, if this could be somehow integrated into training of medical students, graduate students.

MS. STARLEEN SCOTT ROBBINS: Well, and I'll tell you one of the goals of the Competencies for Working with Women and Girls was to actually be able to have

that document be a live document and to be used with universities and training.

DR. VELMA MCBRIDE MURRY: Yes.

MS. STARLEEN SCOTT ROBBINS: And even in some respects picked up by some of the licensing boards around, you know, the competencies that you'd be looking at and maybe a specialty certificate or something like that. So you're absolutely right. It's not something that you tend to just find as a part of a curriculum for folks who are being trained.

DR. VELMA MCBRIDE MURRY: Exactly. So how might that dissemination be much broader, widespread.

MS. SARAH WURZBURG: And I guess the other thing I would add at a larger NASADAD level, the National Treatment Network actually has a Workforce Development Committee, and the National Prevention Network does as well. And the National Prevention Network has actually really been trying to focus on the higher education piece, particularly because prevention -- you know, prevention certification is not as common as, you know, addiction counseling certification.

So they really have been trying to look at what universities have the certification at a bachelor's level as well as at a master's degree level. And then trying to see -- you know, they've had a call with someone from South Dakota and Oklahoma, which are the two master's level programs for prevention, and trying to figure out how to work that into curriculum in their State, whether it be, you know, at a community college level or at a higher level.

But I think there's definitely -- I think that's a great question. I think the NTN, as well as the WSN, is very interested in trying to figure out how to make that connection. So if you have any ideas, that would be great.

DR. VELMA MCBRIDE MURRY: I'll be in touch with some possibilities in terms of -- I know one would be the American Psychological Association. They're very open to really bringing in much more practical training experiences for clinical folks. But I'll be in touch.

MS. SHARON AMATETTI: Let me interrupt for a minute. Nadine has an announcement.

MS. NADINE BENTON: I really do apologize, but we have a -- someone coming in to do a national webinar in this room, which means that we need to move.

MS. SHARON AMATETTI: There was a mix-up.

MS. NEVINE GAHED: We're trying to see if we can keep you here. So can you

-- 2 seconds?

MS. SHARON AMATETTI: Certainly.

MS. NADINE BENTON: Two seconds, about what I wanted to say.

MS. HARRIET C. FORMAN: Could I ask a question? Harriet. I'm wondering if the needs of particularly within a subgroup of women is whether the needs of the lesbian population is also focused on within these materials. The incidence of alcoholism has been widely noted among lesbian populations. So is this addressed?

MS. STARLEEN SCOTT ROBBINS: In the -- in the Guidance to States document, it is not. They are not directly. There is a section in there that we talk about additional considerations, and they are listed as one of the populations that need additional consideration when looking at the 25 elements. And I can't recall in the Core Competencies if we speak --

MS. SHARON AMATETTI: It does speak to them.

MS. STARLEEN SCOTT ROBBINS: Does it?

MS. SHARON AMATETTI: Yes.

MS. STARLEEN SCOTT ROBBINS: Okay.

MS. SHARON AMATETTI: But I think the broader question might have been is the network really -- is that an issue that's championed by the Women's Services Network?

MS. STARLEEN SCOTT ROBBINS: It has not directly. The population has not directly been championed, no.

DR. JEAN CAMPBELL: It would be good to get someone with lived experience to champion that.

MS. SARAH WURZBURG: And as a whole, NASADAD actually has looked at LGBT issues, and we, you know, have looked at that within our membership. And the Board of Directors are very interested in that topic as well. So they actually did form a workgroup on that.

MS. SHARON AMATETTI: We're a little bit in a limbo here as we wait to see if we are going to be moved. I don't even -- I can't even comprehend how that happened, but --

DR. SHELLY F. GREENFIELD: Where are they on the Web? It's on the Web or

--

MS. STARLEEN SCOTT ROBBINS: The Core Competencies?

DR. SHELLY F. GREENFIELD: Yeah, yeah.

MS. STARLEEN SCOTT ROBBINS: It's on the SAMHSA Web site, and if you -- you can actually go into the search. If you put "core competencies," it will pop up, and you can get, I think, up to 25 free copies at a time.

DR. SHELLY F. GREENFIELD: Great.

MS. SARAH WURZBURG: And then the Guidance to the States document is on the NASADAD Web site, as well as the Therapeutic Services for Children.

MS. SHARON AMATETTI: One issue that might come up today, and not necessarily is a WSN-specific issue, but it could be, is related to the announcement made yesterday by Attorney General Holder about the changes in mandatory sentencing for nonviolent minor drug offenses, and what is that going to mean for our field? What is it going to mean for the drug courts? What is it for other types of courts?

What's it going to mean for persons who used to receive addiction treatment services when incarcerated? How is this going to change our field, and is there something that the WSN can be doing really to prepare in their States for what's coming down the road?

MS. STARLEEN SCOTT ROBBINS: Certainly. Because that is going to increase the need for expanded resources if folks actually can be in the community, as opposed to being incarcerated.

MS. SHARON AMATETTI: We're here to stay?

MS. NADINE BENTON: We're here to stay.

MS. SHARON AMATETTI: Woo-hoo. Thank you for whoever made that happen.

MS. NADINE BENTON: My apologies for the disruption.

MS. SHARON AMATETTI: Okay. Good. Obviously, nobody even heard that that was a problem --

[Laughter.]

FEMALE SPEAKER: It was that magic.

[Laughter.]

MS. SHARON AMATETTI: What else do you want to tell the WSN? If you had this -- if you had an opportunity to go to their business day and saw all of these very vibrant and exciting women, what would you want to tell them? What are the issues that you think should be brought to their attention, committee members?

DR. CAROLE WARSHAW: Well, this is Carole. Starleen and I already talked, and you had mentioned this last time about trying to integrate some of the work around DV and substance abuse coercion and bringing some of the resources that we have and thinking together about how to infuse that.

MS. STARLEEN SCOTT ROBBINS: So we've connected, and we're actually going to have a phone call with Carole to talk about how we can coordinate.

MS. SHARON AMATETTI: Oh, that's great. Is that scheduled?

MS. STARLEEN SCOTT ROBBINS: No.

MS. SHARON AMATETTI: Not yet?

MS. STARLEEN SCOTT ROBBINS: We just talked --

[Laughter.]

MS. STARLEEN SCOTT ROBBINS: Before the --

MS. SHARON AMATETTI: You have nothing scheduled yet?

[Crosstalk.]

MS. SHARON AMATETTI: You're such an efficient group.

MS. STARLEEN SCOTT ROBBINS: I was trying to get it in when she was talking.

MS. SHARON AMATETTI: Oh, yes, you were trying to. Okay. So there you go. That's great.

DR. JEAN CAMPBELL: That's why face-to-face meetings work so much better.

MS. SHARON AMATETTI: They do. That's right.

MS. JOHANNA BERGAN: I just have a question. So do you -- does the WSN

meet face-to-face officially in any way, or are you a very virtual community of resources?

MS. STARLEEN SCOTT ROBBINS: Once a year we meet face-to-face.

MS. JOHANNA BERGAN: You do meet? Okay. Okay.

MS. STARLEEN SCOTT ROBBINS: Yes.

MS. SHARON AMATETTI: Which is very important.

MS. STARLEEN SCOTT ROBBINS: It is, and it's a -- it is a packed day. And especially when we have elections, but we usually have representation. Usually Sharon is there, and usually we have a guest speaker, and then we do our business. But we also get our report-outs from each of the subcommittees and any of the workgroups about their outcomes for the year, as well as do our goal planning for the next year.

MS. SARAH WURZBURG: But the rest of the year, we actually have quarterly conference calls for each of the subcommittees, as well as the Executive Committee, and we've been doing webinars as well. So it is heavily virtual. As you can imagine, all the States and the territories, even when we're able to come together, you know, not every State can get approval. So the virtual piece of it is really critical. Teleconferences and webinars are the standard practice.

MS. SHARON AMATETTI: SAMHSA provides a grant to NASADAD to help underwrite some of the travel costs for the WSN's to go to that day. So there's been pretty good participation.

MS. JOHANNA BERGAN: Sure.

MS. SHARON AMATETTI: They don't always get approval.

DR. VELMA MCBRIDE MURRY: This is such a powerful force, and in light of what we've been talking about today, I'm just wondering how might public awareness of the potential leverage that can be gained for women's issues as a consequence of the merging of all of these very powerful systems. And just an awareness that groups of people have come together across numerous venues for the purpose of really focusing on women and girls' issues. It just occurred to me it's a powerful group.

DR. CAROLE WARSHAW: You know, thinking -- this is Carole -- about some of the outcomes of having coordinated services or dedicated champions and putting the resources into making that happen and what a difference that could make as an argument for why that should happen more.

Second thing is as some of the States are merging mental health and substance abuse, because there isn't any equivalent on the mental health side and there should be, and how to influence. You know, we talked about that at an earlier meeting, how to influence that as something that should be happening as well and how to think about the lessons learned from your work.

And the other thing I'm thinking about is the parenting and, you know, the prevention end and what kind of work is going on there. And then, you know, some of the work, you know, from the National Child Traumatic Stress Network around child trauma and parenting or child-parent psychotherapy, ways that actually really help restore the parent-child bond. And whether you're doing work including that kind of work in what you're doing or not.

I don't know what the opportunities are, but thinking about some of those overlaps.

MS. STARLEEN SCOTT ROBBINS: Well, I can -- well, first of all, a number of the women's services coordinators wear multiple hats. So some of them are like -- and they're not at our business day meeting because they're in the NTN meeting and they're in the NPN meeting because they're the representatives for more than one network. But I think for most of the women's services coordinators, our prevention partners are extremely involved and important as a part of kind of our therapeutic services piece and that continuum of services that needs to occur for kids, the prevention, intervention, early intervention services.

I know for us in North Carolina that our prevention folks offer our different evidence-based practices, including strengthening families and celebrating families, and a number of other parenting-based programs that our women treatment providers depend on for parenting evidence-based practice services. So I think that coordination is there and can be available to the treatment folks on the treatment side.

And I just -- I guess about a third of our WSN's hold hats in other arenas than just are the women's services coordinator. So they actually have some control over how much that cross-fertilization happens, which is nice, too.

MS. SHARON AMATETTI: What do you think the extent is to which they cross-fertilize with the mental health block grant oversight, if any?

MS. SARAH WURZBURG: Oh, boy. It's hard to speculate because we haven't really asked that question, for one thing.

MS. STARLEEN SCOTT ROBBINS: And there's a lot of transition happening like right now.

MS. SARAH WURZBURG: Yeah.

MS. STARLEEN SCOTT ROBBINS: So one of the conversations we had when we were at our business day was, what, maybe 10 or 12 States are going through some kind of integration currently where their State agencies are coming together, mental health and substance abuse. There were quite a few.

MS. SARAH WURZBURG: And sometimes even within States that are integrated or in the same house, the facility, you know, they can be quite separate still.

MS. STARLEEN SCOTT ROBBINS: Right.

MS. SARAH WURZBURG: So since we haven't really asked, I think it's really difficult to speculate on that one.

MS. STARLEEN SCOTT ROBBINS: And in North Carolina, we have all three disabilities together -- mental health, developmental disabilities, and substance abuse, all in the same division. And back in 2003, we went from separate disabilities under the same roof to a kind of under functional areas. So I'm on the community policy management on the best practice team, which has all three disability representations and child and adult under the same team.

And so, I actually do clinical policy for both mental health and substance abuse, not -- and then I'm also helping in the coordination and facilitation of policy for IDD as well, as we kind of change how we're doing things and how we're working.

DR. JEAN CAMPBELL: Leading the way.

MS. SHARON AMATETTI: Johanna, you probably would be a good resource to NASADAD as they develop their adolescent standards.

MS. JOHANNA BERGAN: I put your name in a big square with an exclamation point.

[Laughter.]

MS. SARAH WURZBURG: I will definitely give you my card, too. The peer -- the peer work that you're doing is something we'd definitely be interested in having a conversation about as well. Because the States who do have it, it is protocols and guidelines when it comes to youth and transition age youth. And peer services is such a huge issue, and for States to have regulations and guidelines around that is a really big deal.

MS. JOHANNA BERGAN: Yeah. We have some very active young adult champions. Yeah.

MS. SHARON AMATETTI: And Velma, you mentioned your work on adolescent girls and mothers and --

DR. VELMA MCBRIDE MURRY: Sure. Would be more than happy to reply.

MS. SHARON AMATETTI: Okay. Well, we're done a little early. If nobody else has any other comments or suggestions for Sarah and Starleen, we'll take them off the hot seat. Thank you very much, ladies.

[Laughter.]

MS. SHARON AMATETTI: Next our Administrator is going to join us to talk about SAMHSA of the future, and I wanted to ask if you all have had a chance to look at the questions that were sent out in preparation?

DR. JEAN CAMPBELL: Where are they?

MS. SHARON AMATETTI: They're in your binder. I'm sorry, Carole?

DR. CAROLE WARSHAW: Chocolate.

MS. SHARON AMATETTI: You're passing out chocolate. Very good.

[Laughter.]

MS. SHARON AMATETTI: It's always good to pass out chocolates before you're about to ask to do some work, and Megan is going to get some cookies, which is great. Thank you.

So all of the advisory committees are having this conversation about the future, the SAMHSA of the future, and it's my understanding that tomorrow, they would like for a representative from all of the councils that are meeting today to be able to give a report-out or at least be on hand, available to speak if called upon about what our committee talked about.

So I am going to ask for a volunteer who would be willing to do that tomorrow, to share the discussion that we have with Administrator Hyde later, tomorrow. So I'll give you all a little bit of time to think about as you rush to volunteer to do that job. Who wants -- who would feel, you know, that they would like to do that?

FEMALE SPEAKER: It's under the tab that says Question Number 6, the SAMHSA of the future leading discussion.

MS. SHARON AMATETTI: So did you all find it? Okay. So I want to give you a little bit of time to read that, actually, in anticipation of our conversation with

Administrator Hyde.

DR. SHELLY F. GREENFIELD: Can I ask you one quick question in terms of posing these questions? Is it part of a -- is there, I mean, for want of a better word, a strategic planning process or something that's ongoing that this is meant to inform? Because that helps me think of all -- how to think about the questions.

MS. SHARON AMATETTI: You know, I don't know a lot of the details, except that SAMHSA has done a lot of strategic planning in our initial -- we had a blueprint. We had initial strategic initiatives. They've gone through some changes as some things have been accomplished, other priorities have sort of risen to the top, kind a sense of how much can we get done in how much time. So they've shifted some.

And I know that Administrator Hyde continues to be very interested in field input about, you know, where we should go and especially as we're getting a little bit better understanding about Affordable Care Act implications. It's a little -- it's in that context.

DR. SHELLY F. GREENFIELD: Okay. Thank you.

MS. SHARON AMATETTI: For those of you on the phone, we are reading and studying.

[Pause.]

DR. SHELLY F. GREENFIELD: Is there the draft strategic initiative? It says Question 2 asks us to consider the draft proposed strategic initiatives, but -- according to page 218. I don't know if we have those.

DR. JEAN CAMPBELL: Yes, it's a thick --

DR. SHELLY F. GREENFIELD: It's a thick thing. One might -- it's on the Web, I'm assuming, right? It's not? It's internal. So it's going to be hard to consider.

MS. SHARON AMATETTI: Yeah.

DR. SHELLY F. GREENFIELD: Maybe verbally we can consider it.

[Laughter.]

DR. JEAN CAMPBELL: I can visualize it in my mind.

MS. SHARON AMATETTI: There is a little bit I can share with you because it's very publicly known, and that is that, you know, we had eight initial strategic initiatives, and we're really narrowing down sort of our scope of priorities right

now. And so, the ones that continue to be at the top of the list is prevention of substance abuse and mental illness -- so the prevention SI -- health systems integration and financing, trauma and justice, recovery support, and then health information technology.

DR. CAROLE WARSHAW: So nothing about treatment?

MS. SHARON AMATETTI: Well, prevention of substance abuse and recovery support. So that's where they would be captured. And I don't know if you remember our conversations from a couple meetings ago where we described that special populations weren't singled out in any of the SIs except, at that time, military families.

So, for instance, women was not a strategic initiative, or women and children was not a strategic initiative. But the hope and plan was that special populations would be addressed through the other strategic initiatives as appropriate.

DR. CAROLE WARSHAW: But overseeing in some way funding, playing a role in overseeing for mental health and substance abuse treatment, federally funded or State publicly funded, that's not part of it really?

MS. SHARON AMATETTI: It is. The purpose of having the strategic initiatives is really to put an additional lens on some issues that the Administrator wants to make sure don't get --

DR. CAROLE WARSHAW: So there, there is a given?

MS. SHARON AMATETTI: It's a given. I mean, that's really what SAMHSA's mission is about.

DR. CAROLE WARSHAW: Okay.

MS. SHARON AMATETTI: And it's how we're organized and the services we fund and our block grants certainly. You know, the largest piece of our budget. Yes, so it's not that we're not doing those.

DR. VINCENT J. FELITTI: Where do we have the strategic initiatives for 2015?

DR. SHELLY F. GREENFIELD: We don't. We were just talking about we don't have them.

DR. VELMA MCBRIDE MURRY: That we don't have. She said it's internal.

DR. SHELLY F. GREENFIELD: It's an internal --

MS. SHARON AMATETTI: Did they put it on the table?

DR. VELMA MCBRIDE MURRY: Four?

FEMALE SPEAKER: No.

DR. VELMA MCBRIDE MURRY: Four initiatives? And that's prevention --

DR. SHELLY F. GREENFIELD: Prevention, health systems integration, and finance; trauma and justice; recovery and support; and electronic health records.

DR. VELMA MCBRIDE MURRY: Health information technology.

MS. SHARON AMATETTI: Do any of you feel that you would want to volunteer for the role of being the reporter tomorrow? Maybe you haven't had that role in a while, and you'd really like to have it?

MS. JOHANNA BERGAN: You miss it.

MS. SHARON AMATETTI: Did you say yes?

MS. JOHANNA BERGAN: No, I --

[Laughter.]

MS. JOHANNA BERGAN: I should say my funny comments louder, right?

DR. VELMA MCBRIDE MURRY: Can we nominate people? If you don't self-nominate, I'm saying that --

MS. SHARON AMATETTI: Self-nomination.

[Laughter.]

MS. SHARON AMATETTI: You can encourage, but --

DR. VELMA MCBRIDE MURRY: I think Jean has a powerful voice of influence.

DR. JEAN CAMPBELL: But I'm very cynical. So --

[Laughter.]

DR. VELMA MCBRIDE MURRY: If we want optimism -- sure, right.

[Crosstalk.]

DR. JEAN CAMPBELL: Yes.

MS. SHARON AMATETTI: Maybe someone who is retiring off the advisory committee wants to have a chance to do it before they leave?

DR. JEAN CAMPBELL: Oh, yes. It's time to give back.

[Laughter.]

[Crosstalk.]

MS. SHARON AMATETTI: We know about your extreme introvert --

DR. VELMA MCBRIDE MURRY: It's another practice for you, Starleen.

MS. STARLEEN SCOTT ROBBINS: Character building.

DR. VELMA MCBRIDE MURRY: Another practice for Starleen.

DR. JEAN CAMPBELL: Well, somebody complained about --

DR. VELMA MCBRIDE MURRY: Oh, yeah, we shared that.

FEMALE SPEAKER: We shared your complaint.

DR. VELMA MCBRIDE MURRY: And Nadine graciously --

FEMALE SPEAKER: Aren't they supposed to be in the boxes?

MS. SHARON AMATETTI: Yes. Nadine brought these herself for you all.

DR. JEAN CAMPBELL: You went through the whole list of things that were missing?

MS. SHARON AMATETTI: She anticipated a need.

FEMALE SPEAKER: How nice.

MS. SHARON AMATETTI: Thank you. That's very nice.

So if you would do some more reading of these, thinking about your -- what you want to share, and then you can take a little break, and then we'll reconvene at 2:15 p.m. with Administrator Hyde. But please continue to think about the questions.

DR. VINCENT J. FELITTI: Let me bring up something provocative.

MS. SHARON AMATETTI: All right.

DR. VINCENT J. FELITTI: Namely that substance abuse is not really the problem. Substance abuse is -- let me correct that. I think substance abuse is a misleading terminology. Substance use is someone's unconscious attempts to resolve problems that we never talk about much. Partly because they're lost in time, partly because we've all been taught as children fairly effectively that nice people don't talk about certain things and, my God, surely don't ask about them, et cetera.

And it seems to me repeatedly that's the big issue that I see missing from the discussions that we have. In other words, what are benefits of smoking? What are the benefits of alcohol, of crystal meth? Does it matter that methamphetamine was the first successful prescription antidepressant introduced in the country in 1940 and held that position for about the next 18 years?

DR. CAROLE WARSHAW: So I guess, you know, that raises a question to me about the integration of the initiatives rather than being siloed in what's possible so that if you're talking about trauma as an underlying issue for, you know, the generation of mental health and substance use problems, how is that -- how is there like a big public health focus, big public policy sitting at the table with economic policy decision-makers not just doing services and prevention, but thinking, raising it to another level that cuts across initiatives?

The same with some of the other ones. You know, maybe think about them. Maybe it works that way already, but just trying to raise all kinds of questions that are the kind of policy level questions.

MS. SHARON AMATETTI: Yeah. Yes, definitely.

DR. VINCENT J. FELITTI: Yeah, kind of like depression is not a disease. Depression is a normal response to abnormal life experiences.

DR. VELMA MCBRIDE MURRY: Exactly.

DR. JEAN CAMPBELL: Well, that's what the existentialists thought.

DR. SHELLY F. GREENFIELD: Well, I just -- I would just -- I would just say that I'm not sure what the whole context of the discussion is, but I think what we know about most disorders, whether they're mental health-related disorders or physical health disorders is that they are actually multifactorial and complex in their etiology and that we know that genetic predisposition and environmental stressors contribute. And within any individual, there is a contribution on both sides where the genetic predisposition can actually overwhelm even whether or not there was a presence or absence of environmental stressors, and

environmental stressors can overwhelm having no genetic predisposition. And in any one individual, there is a very complex interplay amongst these things.

So, you know, I hesitate to ascribe etiology broadly to any of the disorders. I mean, there are people who have profound genetic predisposition to depression, for example. And in the absence of life stressors, they will, in fact, manifest the disorder.

And the other side of it is there are people aware that's not even in their familial -- you know, their family history, and they are exposed to tremendous stress, and they will evolve the disorder. We know there are even epigenetic factors now where -- so I just -- I guess I'm -- you know, I want to be very careful in formulating policies or ways of managing where services are based on, you know, what I think are sort of multifactorial etiologies for all of these disorders that we talk about.

DR. VINCENT J. FELITTI: Well, all of that's true. But to really understand that numerically, you'd have to get detailed life histories on people, developmental histories on them. What are the differences between 1,000 people who are suicidal and 1,000 people who have never been suicidal in terms of early life experiences? And that's something notably that's absent.

DR. SHELLY F. GREENFIELD: Again, I think in like the 5 to 10 minutes we have, it's a really complicated area. But there are -- there are considerable -- there is considerable data that extends from epidemiologic studies to genetic studies to twin studies that have looked at environmental factors versus genetic risk. And you know, there are fairly compelling studies over 40 or 50 years that show there is a, you know, 40 to 60 percent contribution overall population wise of genetics to the evolution of substance use disorders and 40 to 60 percent on the other way.

So it's not -- you're not all about your genes, nor are you all about your environment. And I think most biomedical diseases really are a complex interplay, and there's a fair amount of data that support that, I think, for both mental health and substance abuse.

DR. VINCENT J. FELITTI: Indeed true. But when people talk about environment, they're usually talking about things like lack of access to a nice park or something like that, not what happened to individuals developmentally.

DR. SHELLY F. GREENFIELD: No. No, I don't think so. I think people are often talking about early life environment, including prenatal environment, where there's now even a fair amount of evidence to show that maternal stress may actually even, in fact, have epigenetic --

DR. VINCENT J. FELITTI: Absolutely.

DR. SHELLY F. GREENFIELD: -- changes for --

DR. VINCENT J. FELITTI: Sure.

DR. SHELLY F. GREENFIELD: -- fetuses who are in development. So I think, actually, environment is usually a writ broad to capture a whole host of things, and I think in the last decade in both substance abuse and in the mental health arena, I think the evolution of information around the actual stress response and the biological effects and then the epigenetic effects of having extreme stress, actually, I think that picture is filling out really from even a biological standpoint pretty persuasively.

I think that research is still evolving. But -- but that said, there are, in fact, in not all circumstances, you know, is it only about the environment. So I just -- there's -- it's, as I said, the best way to capture it, I think, is that there's fairly compelling evidence, that it's very multifactorial in origin.

Anyway, I'm only just placing that context. I'm not sure how that -- what that means for the overarching discussion about SAMHSA's priorities. I just wanted to contribute -- contribute that perspective.

MS. SHARON AMATETTI: And I think those are both really good contributions, and you're, I'm sure, going to hear Administrator Hyde talk about the concept of SAMHSA as a public health agency and what does that mean? And language is really important, and we've had the dialogue for several years now about behavioral health, you know? Some people are comfortable with it. Others are not. What does that really mean? What does it mean about the person?

And understanding, understanding the scope of the issues and what we -- are our core issues? And so, the conversation today should be about what should be SAMHSA's core issues. How do we see ourselves in the context of a changing healthcare environment?

DR. VELMA MCBRIDE MURRY: One question. And I'm not sure of the appropriateness of it, but I'm wondering if there are territorial issues that we need to be mindful of as well as we go to this discussion? Are there other institutions that are considering themselves as behavioral health agencies, and what then do we need to focus on in terms of the uniqueness of SAMHSA from those other institutions so that there isn't the sense of conflict?

MS. SHARON AMATETTI: Well, that's a good issue you raise. And you know, when SAMHSA was actually created, we were part of ADAMHA, and then we were spun off from the research institutes, and we were -- to not be a research institute, we were supposed to be a service agency. Well, that's one of the things we want to talk about, you know, the extent to which that works for us, for

them, for taxpayers, and some artificial things that are created as a result.

They were trying to create some efficiencies. Is that working? What is the SAMHSA of the future?

DR. VELMA MCBRIDE MURRY: And I think legitimate in light of where the other behavioral-focused unit is going --

DR. CAROLE WARSHAW: Where, what other -- are you talking about NIMH?

DR. VELMA MCBRIDE MURRY: Yes. In particular.

DR. CAROLE WARSHAW: Okay. So they're becoming more biologically oriented.

DR. JEAN CAMPBELL: Well, they've always been, and there's been a real lack of services research.

DR. VELMA MCBRIDE MURRY: Yes. Oh, yes.

DR. JEAN CAMPBELL: And in fact, the evidence-based practices that we now support were a result of SAMHSA funding multisite studies --

DR. VELMA MCBRIDE MURRY: Yep.

DR. JEAN CAMPBELL: -- that really gave a push to supported housing, children support, recovery-based model. All of those were -- consumer-operated service programs were all multisite studies.

MS. SHARON AMATETTI: And if you look over what the research institutes are funding, some of it is services also. So --

DR. JEAN CAMPBELL: It's very -- I mean, the majority --

MS. SHARON AMATETTI: There's seepage.

DR. JEAN CAMPBELL: And they don't -- the way they organize multisite studies as well is very strange compared to some sort of targeted focus to pull, you know, to have the announcement say the multisite -- the model we developed at SAMHSA for doing multisite studies I think was much more effective. So it was a loss to research and, I think, to services when that was taken away, agreed upon or --

DR. CAROLE WARSHAW: Are there other issues we should be thinking about like these that aren't in the questions that we should be informed about?

[Laughter.]

MS. SHARON AMATETTI: Everything's in the questions. It's how you read the questions.

[Crosstalk.]

MS. SHARON AMATETTI: You have to know how to read them. It's between the lines, between the lines.

DR. JEAN CAMPBELL: Well, the first question could include what we just said. You can stretch it.

DR. SHELLY F. GREENFIELD: You know, I guess one of the things that, you know, is difficult is that, you know -- and you all know this probably even -- well, I think we all know is that in the face of constrained resources, each institute or organization is faced with how -- where to -- you know, how to keep everything going that one wants to and needs -- that one needs to keep going. And sometimes, you know, other things get squeezed out.

And you know, one of the -- I think the services-related research has been an area that's been hard to continue to, you know, prioritize whichever place you look. So no matter which institute or organization you're going to, that's often fallen to the bottom, and it's gotten squeezed out. And so, you know, I think, you know, it seems relevant to re-raise the issue of where is that going to be getting done, you know, in this broad -- you know, with all these new changes that are going to be happening.

And if you're really going to talk about wellness of the population through the life span, where is the research going to be getting done that's going to demonstrate that you can integrate certain kinds of practices into general care in such a way that you will improve ultimately, you know, the population's health. You know, and that -- I think the frustration for anyone who's done any mental health services research is that some of the downstream effects are outside the bucket that is usually looked at.

So if you're treating people and they are outside -- they are staying outside of the criminal justice system, you don't get to count that toward the healthcare budget. If you're treating, you know, substance use and people are staying employed and staying in their housing and continuing their families, all those effects you don't get to count that, you know, as your cost-effective, you know, bottom line. And so, you know, there's a lot of -- there's been a lot of trouble, I would say, around hitting that type of research that's really pretty important if you're going to be investing in a healthcare system that you're hoping is going to keep people well.

So, I mean, that's a kind of big topic. I don't know where that fits in the questions, but it's a pretty important topic if the U.S. is going to invest, you know, in what I think we all know we have pockets of evidence that show you invest in this and people actually do better. They feel better, and we actually are able to prevent a whole host of other kinds of medical, you know, illnesses that are very somatic and have their origins in a lot of these other things that don't generally get treated.

So where does that research take place? And it's been very difficult, I think, to -- you know, it's been done in pockets because we have evidence. But it's not been done in the same kind of comprehensive, systematic way that I think a lot of us would wish we could, you know, do. And I think on a public health -- if you're talking about being a public health organization, I think that's really pretty important, you know, overarchingly.

I mean, when you can see -- when you can -- you know, it's a little bit like Head Start. You know, Head Start was an educational effort for small children that showed it had, you know, enormous benefits in terms of, you know, cognition and overarching health and even brought benefits back to the family, you know? So, I mean, where do you put that in the kind of --

DR. JEAN CAMPBELL: But the downstream is, you know, less incarceration.

DR. SHELLY F. GREENFIELD: Exactly. Exactly. So, I mean, you know, in other words --

MS. HARRIET C. FORMAN: Less special education later on.

DR. SHELLY F. GREENFIELD: So that's a -- you know, that's a "educational program" that had downstream health effects. You could think of all the health early interventions that have downstream education effects and all the other. So how do you kind of, you know, do that, you know?

If you're going to invest the money in the healthcare system, it would be good to be able to count the benefits toward the investment, you know? And if you're only going to parcel out what you're allowed to count, you're not really doing the accounting very well, and you know --

MS. HARRIET C. FORMAN: It's money you don't have to spend later.

DR. VELMA MCBRIDE MURRY: I think it speaks to what you were saying earlier --

DR. JEAN CAMPBELL: Well, you know, that's a real critique --

DR. VELMA MCBRIDE MURRY: -- and that there needs to be a much broader -

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DR. JEAN CAMPBELL: -- of the national framework that has been proposed because it doesn't count any of those positive impacts outside, and it's more focused on the clinical population and improvements that they make.

DR. CAROLE WARSHAW: Right. It's not like public health.

DR. JEAN CAMPBELL: But --

DR. CAROLE WARSHAW: I mean, public mental health has meant services for people who don't otherwise get them, as opposed to what would public mental health really look like or mean? And thinking about some of the World Health Organization criteria for what public health is, which includes, you know, safety and economic stuff, all those kinds of things.

MS. SHARON AMATETTI: You know, I'm thinking let's save a little bit of this for when Pam is here because I'd like her to hear this, too.

[Laughter.]

DR. JEAN CAMPBELL: We're practicing.

MS. SHARON AMATETTI: Oh, you're practicing? And remember -- and remember also your gender -- a gendered lens, if that has any relevance to the conversation.

So let me give you opportunity to take a short break, and we'll reconvene at 2:15 p.m. when she joins us, okay? Thanks.

[Break at 2:05 p.m.]
[Reconvened at 2:21 p.m.]

MS. SHARON AMATETTI: We're going to get started. Happy to welcome Administrator Hyde.

MS. PAMELA S. HYDE: See, I already have notes and notes and notes from my other committees.

MS. SHARON AMATETTI: Good. Getting a lot of great ideas, and that will continue here, I'm sure, from our pre-discussion on this topic.

Let's go around the room and just say hello and your name, if you would, for --

MS. STARLEEN SCOTT ROBBINS: Starleen Scott Robbins, WSN and North Carolina women's services coordinator.

DR. SHELLY F. GREENFIELD: Shelly Greenfield, an addiction psychiatrist and a colleague of Ellie McCance-Katz's. I'm at McLean Hospital in Harvard Medical School.

MS. PAMELA S. HYDE: Fantastic.

DR. JEAN CAMPBELL: And you know me already. I've said my hellos.

[Laughter.]

DR. CAROLE WARSHAW: I'm Carole Warshaw, National Center on Domestic Violence, Trauma, and Mental Health.

MS. PAMELA S. HYDE: Great.

MS. JOHANNA BERGAN: I'm Johanna Bergan, Director of Member Services, Youth MOVE National.

MS. PAMELA S. HYDE: Yeah, great organization.

MS. HARRIET C. FORMAN: Harriet Forman.

DR. VELMA MCBRIDE MURRY: I'm Velma McBride Murry, a professor at Vanderbilt University.

MS. SHARON AMATETTI: And Vince Felitti stepped out of the room, but he'll be back.

MS. PAMELA S. HYDE: Good for him.

DR. JEAN CAMPBELL: This is a great, great committee of women.

[Laughter.]

MS. PAMELA S. HYDE: So who are we missing? Do you have anybody on the phone?

MS. SHARON AMATETTI: No members are on the phone. Rosalind Wiseman is out of the country, and Yolanda is also not here today.

MS. PAMELA S. HYDE: Okay.

MS. SHARON AMATETTI: But that's our whole committee.

Agenda Item: The SAMHSA of the Future: Committee Discussion

MS. PAMELA S. HYDE: All right. Well, great. Thank you for letting me sit in here a little bit.

Kana, of course, sends her greetings. She -- you know, it's just really hard for us to do tag-teaming, and there was no way for her to get time off and me to get time off and us not to be off at the same time without her being gone this week. So -- so she is off doing whatever she needs to do with family things and other stuff this week.

But she sends her regards, and obviously, Nevine and Sharon and I and everybody else will feedback for her the conversation. So I know she really enjoys this time. So I know she misses it.

So let me just give you a little bit of context. You may have done some of this, Sharon, I don't know. But I'll give you a little context. I've been council-hopping today. So I've heard some of the other conversations already, but I think I get to stay the whole hour with you guys, as opposed to --

DR. VELMA MCBRIDE MURRY: Yay.

MS. PAMELA S. HYDE: -- in some of the other. How much time do we have here?

MR. JOSH SHAPIRO: Until 3:45 p.m.

MS. PAMELA S. HYDE: Until 3:45 p.m.?

MS. SHARON AMATETTI: Actually, quite long.

MS. PAMELA S. HYDE: Fantastic. Oh, that's a long time. All right. I'm usually popping in for 20 minutes and back out.

But anyway, so let me tell you just sort of kind of where this came from or how we think of this effort and why we wanted to come back to you all as councils and advisers and say what do you think, what would you tell us to help us think about what the SAMHSA of the future should be? Specifically not the future of SAMHSA, but the SAMHSA of the future.

We're about 20 years old. You all know we had a 20th anniversary last year, and the world is a significantly different place today than it was 20 years ago. Some of us remember that time. We were in the middle of our careers then, and now we're maybe at the kind of other end of our careers. But nevertheless, the

changes that are going on out there are pretty profound.

I mean, at this point, mental health and substance abuse treatment services are largely funded by insurance, either Medicaid and Medicare or private insurance. About two-thirds of those treatment dollars are spent there or come from there. That number is before the ACA. So that's before we add a bunch more people to private insurance and, in some States anyway, more people to Medicaid. And frankly, as the world ages or as the country ages, more people on Medicare.

So I don't know what that number will look like in another 10 years, but you can imagine it's going to be more than 60 percent, 60-65 percent. We, if you put the circle together, there'd be a little 0.5 percent, and we sit inside that 0.5 percent as Federal -- other Federal dollars. So we're really a very small part of the overall expenditure for mental health and substance abuse services.

If you look at the healthcare delivery system, mental health is about 6 percent, and substance abuse is only about 1 percent. Now these are largely treatment services. So prevention services may be different a little bit. We may be a much bigger piece of that pie, and recovery support services, it's hard to -- it's hard to make a statement about that because some of those are covered by insurance and some of them are not. But you get my point. We are not the biggest funder in the world is my point.

We are a relatively small Federal agency. We are only about $3.4 billion. That may sound like a lot, but that's for the entire country, and you know, we used to laugh when I was a State commissioner that what we spent in New Mexico was a rounding error in Pennsylvania, for example.

[Laughter.]

MS. PAMELA S. HYDE: And it's even worse than that here. So they literally spend more per hour on Medicaid services. They push out the door more money per hour than we have in a whole year for the whole country. So, I mean, we're tiny is my point.

Now having said that, that's not to say we're not mighty. We have a unique role perhaps, and our funding is about -- again, about two-thirds of our funding, 60 percent is block grant. So that money goes out to the States, all 50-plus States -- some of the jurisdictions get them as well and, in one case, one tribe.

But anyway, that money goes out with some very high-level parameters, and we can encourage, shift, move, ask people to do things a certain way. But we don't have tons of control over what the States do with that money. We have less control than you perhaps think, and we've pushed the edges of that about as far as we can push it. But the lawyers push back and say we can't require certain things that we might like to require.

In addition to that, there's about 62.5 million people in this country who are about to get expanded coverage or coverage for the first time of mental health and substance abuse services because of a combination, the confluence of the Affordable Care Act and MHPAEA, or parity.

So you put those two things together, and we're about ready to come out with a final rule on MHPAEA, and Affordable Care Act obviously is starting into the fall. Enroll everybody, and after January 1st, lots more people will be on coverage, and we think it will take a couple years to get everybody fully up. But nevertheless, 62.5 million people are going to have access to coverage for these things that we've been concerned about than ever before. And about 11 million of those 62 million, we estimate will have, in fact, mental health and substance abuse -- and/or substance abuse problems.

Now, again, having said all that, those are just some statistics to say the world is changing big time, and the other thing that's changing in our -- in our world is SAMHSA is also a really unique agency. We're the only agency I think in the Federal Government, unless you go down inside CDC or something, we're the only operating division of an agency that is focused around a set of conditions.

So everybody else is focused on a population. So either young people, old people, people with disabilities, you know, whatever, or women or minorities or whatever, and others are focused on functions. So like CMS is a payer of services. They purchase services. CDC or NIMH or NIH are either researchers of services, or they are, you know, data gatherers or whatever. But we're the only one that's really focused on a set of conditions, and there's probably a historical reason for that.

That history is changing because we are more and more becoming a part of overall healthcare, which is a good thing. But we're not completely there in terms of history or laws or funding levels or anything else.

The good side is that everybody is starting to get that behavioral health matters. So CDC is all over this. The Administration on Children and Families is all over the issue of trauma and substance abuse among either the young people that come into their systems or the parents who are having trouble, and that's why their kids into those systems. So they're paying big-time attention to it.

The new Administration on Community Living is big time paying attention to mental health and mostly on the mental health side as a disability. Medicaid and Medicare are totally getting that these conditions are driving some of their costs. So there's just everybody. The VA, the Department of Defense, I mean, you name it, Justice, everybody.

AG just came out this week, if you watched that, with a major statement about

sentencing for people with substance abuse. Now this is a very good thing. But think about if overnight the States really did what the AG asked for and stopped putting substance users in prison and jail. My goodness, what would we do with them in terms of treatment, and we just don't have the infrastructure there to manage all this.

So, again, that's a lot of background to say we have been doing a lot of thinking here at SAMHSA about what should SAMHSA look like in the future? How can we think about our appropriate role when we're such a little, tiny, but unique organization?

Our dollars are dwindling. They're not getting bigger. They're getting less. We have been known as a grant-making organization, and that's a good thing. We will continue to give out grants. But frankly, in the larger scheme of things, our grant making is relatively a drop in the bucket.

So the other things we do is a major set of surveillance and data collection. We do a major set of practice improvement efforts, training, technical assistance, all that kind of stuff. We do a lot of public education, teaching the country about things and getting information out to the country. We do a lot of regulatory stuff, especially in the substance abuse world with buprenorphine and methadone and workplace drug testing efforts and such.

So we have major other functions that people don't often think of us about. So workplace drug testing alone touches about 75 million Americans. So even though we're a little, tiny organization, we do stuff that touches lots and lots of people. But we don't, frankly, get a lot of the credit for that, and people don't know us for that too much.

So that's the long story, and I want to stop talking because I want you to talk to me. But, so we started thinking about how to engineer, how to re-engineer SAMHSA, and we've been working on something we call internal operating strategies, or IOSs, and we're thinking about everything from business practices to staff development, to our staff capacity to use data, to our staff capacity to do communications, and our health reform capacity. So not so much the external stuff, but our just staff's capacity to manage in this kind of an insurance-based world.

So we've been thinking about this. We have seven IOSs, and we crafted a set of questions that we wanted to ask our advisers because you are -- that's what you are. And you give us incredibly stimulating input every time we get to meet with you and in between as well.

So these questions we have been going through with each of the councils. And tomorrow, Brian, who's actually here trying to jump around and listen to the conversations as well, he's going to facilitate tomorrow sort of a report-out. And

we would like each of the councils to come up with at least two real clear and distinct messages about what you think we should be thinking about as for the SAMHSA of the future.

So you need to think about who your reporter is going to be. It should be one of the council members, not a staff person. And then we just need to have a little bit of a conversation about that. We can either do it one of two ways. We can go down through the questions one by one, if you want. There is some overlap to the questions. They're a little -- they were meant to be more stimulating than literally, you know, write something under each question.

So how we do that is fairly open-ended. So I will maybe just open the floor up at this point. Do you have a way when you have report-outs that you choose people, Sharon, or --

MS. SHARON AMATETTI: Well, I think --

FEMALE SPEAKER: Whoever is out of the room.

MS. PAMELA S. HYDE: Whoever is out of the room? It's a good thing you came back in, Vince, or you would have been it.

MS. SHARON AMATETTI: We don't want to put anyone on the spot.

MS. PAMELA S. HYDE: So who wants to be the person that kind of takes some notes here? We can help. Staff, I think, can help take some notes. But whoever is willing to be on Brian's panel tomorrow, let's figure that out first.

MS. SHARON AMATETTI: They were all jumping at the bit when I suggested this earlier and crawling over each other.

MS. JOHANNA BERGAN: I could report out.

MS. PAMELA S. HYDE: Okay, great.

MS. SHARON AMATETTI: Okay, Johanna.

MS. PAMELA S. HYDE: All right. So we will kind of help take notes for Johanna, but the floor is open. I don't think we need to --

DR. VELMA MCBRIDE MURRY: We actually started --

MS. PAMELA S. HYDE: Okay. Good. Great.

DR. VELMA MCBRIDE MURRY: -- Administrator Hyde, with a question. And so, what I posed was whether or not our discussion should be taking -- should

consider the potential competition of other institutions or agencies, and I think you named some of them, like CDC and NIMH, in the context of our thinking about the restructuring of SAMHSA. And then as you were talking, that my question really morphed into thinking about the history and the position of SAMHSA, how might that be leveraged? If there are competitive, territorial positions being taken, how might we leverage SAMHSA?

So we have -- I started with a big question of as I look at these questions, shall I think of it in terms of how to position SAMHSA in a way that the territory that other people may think that they have with regard to behavioral health, how should we think about that? So --

MS. PAMELA S. HYDE: Boy, that's -- I mean, that's a good question and sort of the question we've asked ourselves a lot. You can argue that people -- I'll give you some examples. Like the Veterans Administration, for example, is doing a ton more in behavioral health now than they have in the past. So maybe they've done it in the past, but it's getting a lot more attention, and they're trying to improve their capacity.

And we have a lot of collaboration with them. For example, they use our Suicide Prevention Lifeline, and we've got it connected so that if a person is on that lifeline and wants to say they're a veteran or a family of a veteran, they can punch 1 and go straight into the veterans lifeline. So we have some real good collaborations in that regard.

They use us for things like, especially in our suicide prevention area, about our expertise. So they were developing toolkits and some other things, and they asked us for -- because we have people here who are subject matter experts and they do a lot of that work.

But on the other hand, to be, you know, sort of stimulating my own self, I guess, so does CDC. I mean, they have --

DR. VELMA MCBRIDE MURRY: Yes, that's right.

MS. PAMELA S. HYDE: They have experts, and so do other organizations have experts. And we spend a lot of time collaborating with those experts. So I know that in the women's area we do. I know in the children's area we do a lot of overlap with DOJ, with ACF, with juvenile justice, all those players.

DR. VELMA MCBRIDE MURRY: So it's the branding of SAMHSA in a way that it becomes the agency.

MS. PAMELA S. HYDE: Well, and I guess the question back to you is, is it important today to have a branded organization that is about substance abuse and mental health at the Federal level?

DR. VELMA MCBRIDE MURRY: Well, we say yes, and that's --

[Laughter.]

DR. JEAN CAMPBELL: Well, you know, I was thinking as you were talking that you could see the structure of HHS with all of these agencies, they're like silos in and of themselves. So then when you think of the area of behavioral health, it's spread across in these different silos, and you have to like pick in and create a connection so it -- you know, your call goes here or there. It's not integrated. I don't know how it would be, but -- but maybe this collaborative model, you know, creating these semi-permeable membranes so that you don't have as much of these institutions that are loyal, you know, and people that are loyal to competing for the similar resources.

And there's a lot of work being done at the CDC that directly relates to what SAMHSA is doing and at NIMH and some of the other agencies you mentioned.

MS. PAMELA S. HYDE: And we do tons of work with them.

DR. VELMA MCBRIDE MURRY: Yeah.

MS. PAMELA S. HYDE: So there's no question about that. I think the question that these questions raise and that we are trying to think about is what's our unique contribution?

DR. VELMA MCBRIDE MURRY: Yes.

MS. PAMELA S. HYDE: And how can we position ourselves to be the best at that unique contribution? So what does the field need, do you think, that only SAMHSA is sort of positioned to do, and how do we make sure that as we go forward, we have the staff infrastructure and knowledge and capacity and flexibility and fluidity to do that stuff? So that is the question.

DR. JEAN CAMPBELL: Well, you know, I had an idea for one area of uniqueness that SAMHSA -- I mean, now with PCORI, maybe it's not as clear. But the -- SAMHSA has had a long history of being sensitive to the lived experience and the patient's voice, and I mean over 20 years' experience, and really understands that dynamic in a way that the CDC and NIMH and VA is starting to include. But I mean, that's one uniqueness.

And one of the things that that's brought is that we've had a vibrant and emerging understanding of behavioral health issues in unique ways. That by including people with lived experience, that's brought greater knowledge to us. And one of those areas has been the recovery-based model. And particularly, and this was an area that I thought that SAMHSA could be unique because other

areas haven't really emphasized it, is the focus on positive health, positive psychology and positive health effects.

And just I know how many times have I brought up the issue of well-being, you know? And even when we were working on this committee with Ron Manderscheid to provide CMHS with some recommendations around data sets, I had to say, well, wait a minute, this committee is part of a wellness, the wellness initiative. And I said, but we're just -- we're still making recommendations that focus on clinical.

And so, I think that there's a real opportunity, and I would -- I suggested to Ron Manderscheid that he share the final document that our committee produced with you. But to start to think about how could we integrate more the positive psychological approaches, we certainly have the concept within recovery. We have the germ, but we haven't as a field expanded that.

I mean, we had the recovery initiative. So there are a few things in that, but I think that we're weighted toward the clinical, and more of positive psychology and bring in people that do positive psychology and how would -- the implications of that, I think that could be something that people would come to us, being SAMHSA, for that knowledge, too.

MS. PAMELA S. HYDE: So let me ask you a question about that. Because for reasons which you might guess, for just some of the things that's been happening over the last few months, but we are often told that we are viewed – we, meaning SAMHSA, are viewed as anti-treatment or on the mental health side anti-psychiatry or whatever you want to call it. So there are people who say we spend too much effort on this recovery --

DR. JEAN CAMPBELL: Well, I know those people.

[Laughter.]

DR. JEAN CAMPBELL: No, I mean I've heard that.

MS. PAMELA S. HYDE: And I mean, just the data I have you a while ago about 60 percent of the treatment services are funded by somebody else. It would make some sense, I guess, that we're funded -- we focus on those things that we either are able to fund or that we are uniquely situated to talk about.

But it's interesting that you say we focus heavily on the clinical often because there is certainly the other view that we don't focus enough on that. So I don't -- I'm not expressing an opinion. I'm just telling you the views.

DR. JEAN CAMPBELL: Yes, but there are other agencies, I would, you know, say -- and proud of it -- that we have a more balanced approach. I don't think we

are balanced enough in that area. But I think it's something. I mean, it's just a small group, although they're very vocal. But that is a small group.

And it certainly isn't consistent with the philosophy of much of the ACA in terms of cost savings and, you know, the focus on public health and prevention.

MS. STARLEEN SCOTT ROBBINS: And certainly, none of the agencies that you mention -- you know, CDC or any of them -- would hold themselves out to be the treatment and recovery experts that I think everybody kind of agrees that you go to SAMHSA if that's what you're looking for. And I don't -- I think SAMHSA can't get away from that, that that is the brand and that is what brings the value to our field.

SAMHSA has the statute. They have the backing. They have the support. And regardless of how much money is behind that, you can't go anyplace else for that. You can't go to CDC for that. You can't go to the Veterans Administration for that. They come to you for that.

And so, that is the uniqueness of SAMHSA, and without it, where do all those people go when they're trying to develop their programs, their policies, their infrastructure around that expertise?

MS. PAMELA S. HYDE: I frequently make the same argument. I'm just giving you -- giving you --

[Laughter.]

MS. PAMELA S. HYDE: No, that's great. I mean your reaction to that is helpful. I mean, the other place, obviously, that we've made a major and profound impact, I think, is in the trauma area. But now other people are getting on that, on that bandwagon big time.

DR. VELMA MCBRIDE MURRY: Models for multisite studies, models for real community-based approaches to addressing issues. I mean, that's -- other people are now claiming it. You're now getting grant applications that say you must include community-based organizations. But it's what SAMHSA, because it's their history.

DR. JEAN CAMPBELL: Yes, it's community engagement --

DR. VELMA MCBRIDE MURRY: Community-engaged approaches for addressing issues of health.

DR. CAROLE WARSHAW: And I think mostly because there's so much pressure to be evidence based, and evidence based excludes a lot of people. And even when you have it, you can't necessarily implement it in communities,

and how to make sure the voices who need to part of building an evidence base are there.

So, I mean, that's -- we're kind of doing that in the DV part of the world. How do you build evidence for things that are much more complicated than most of the clinical trials? How do you support thinking about that and best practices? And leveraging resources to kind of build evidence that comes from practice in communities in ways that are meaningful to people.

DR. JEAN CAMPBELL: And also scalability of the program.

DR. CAROLE WARSHAW: Which is a really huge issue. So how to set the kind of standards for best practices that has some of that fluidity and voice in them that aren't just kind of fragmented. Whoever writes the research proposal and gets it funded, that's what the standards are, as opposed to a thoughtful process that includes voices to look at what's the best of what we know? Where do we need research? How is it going to move that forward? Where are the limits of research, and what are the gaps that we can fill in in a more comprehensive way to think about that?

The other thing we were talking about a little bit is like what is public mental health? I mean, it's been services for people who couldn't access services otherwise. And if you wanted to think about preventive public mental health, what would that look like? How would you elevate some of the trauma work and some of the other disparities work? Not just about services, but CDC doesn't really do that. And so, what would that look like?

Where you put the resources in a place where it's going to make a difference over time for those investments. Oh, sure, there's NCTSN, but there are people doing that. It's not like a broader picture.

MS. PAMELA S. HYDE: So we have been talking a lot about being a public health agency. So it's interesting if you look at the names of some of the HHS agencies. There's some that are centers, like the Center on Medicaid and Medicare Services or the Center for Disease Control and Prevention. I mean, it's actually a longer name and turns out to be CDC. But anyway.

And there's folks like us that our name says "services administration." And HRSA's name says "services administration." And then, of course, there is the institutes. So they have different names.

I had a conversation with Mary Wakefield at one point about this because her name is similar to our name. Her agency's name is similar to ours. And I said how do you see that? And she said she saw it as part public health and part services administration.

We have been consistently trying to reclaim the public health aspect of our agency and say that even in the grants we administer, we should be thinking of it in a public health approach. But having said that, you just used the term "public mental health." So I wanted to ask you what you kind of were thinking when you used that term?

DR. CAROLE WARSHAW: Well, I was thinking about what -- I mean, it fits with well-being. You know, it fits with prevention. So there's all the services, but there's like what are the things that support, you know, mental health and well-being? So there's all the trauma work. There's all the investment in supporting kids and parenting. There's all the economic disparities.

You know, like Brian talking about investing in -- how do you invest in early childhood development and protective factors for social and emotional well-being, but elevating that in a way that cuts across not just those particular grant-funded programs. But I mean, one thing that I think about a lot is like SAMHSA and HHS should be sitting at the tables where people are making economic policy decisions, and where do resources go and what's the investment in public health and public well-being or public mental health?

Because that's like everything else is going the opposite direction, and we're trying to patch up, you know, as best we can. And to really create a discourse that at least raises that, especially at times like this. Where do you invest to kind of create -- there's a lot of people talking about it, about education, technology and who's going to keep our economy strong. But if you don't think about all the things that we don't think about, you're not going to get there either.

MS. PAMELA S. HYDE: Yeah, it's thought about a lot in terms of social determinants of health and stuff like that.

DR. CAROLE WARSHAW: Right. Right.

MS. PAMELA S. HYDE: They're actually trying to put some of that together with economic issues in particular communities. So they've got a city that's called SC2, again, acronyms. Then I forget what they mean. But SC2 was a proposal out of the White House or a project out of the White House that targeted six different cities.

New Orleans was one of them because we sent a person there to work on it for a few months. So they were really focusing on the community, the economy, the behavioral health. At least in New Orleans, the interface between mental health and substance abuse and jails -- and jail issues. So rather than building 1,600 more jail cells, they were really trying to take on the issue of juvenile violence and gun violence and substance abuse and mental health access to services, et cetera.

So --

DR. CAROLE WARSHAW: Well, I remember like Stephanie Covington talking about in one of her -- something she wrote about, you know, talking to women post incarceration around re-entry and what are the wrap-around services that would help you kind of stay out of jail. And they're the same things that would have prevented women from being incarcerated in the first place.

So it's like thinking in that kind of that array of resources that people need that support health, mental health, and well-being. And in a larger scale, maybe in terms of, you know, how we do public awareness, how you think about services and prevention. It's just no one else is filling --

DR. JEAN CAMPBELL: You'd get criticized again. But moving away from an emphasis on the sickest of the sick. Again, I meant we're told that that's who we should be focusing on. But it seems like everything that SAMHSA, I think really -- the SAMHSA of the future that would address the issues of the future goes in that direction. Instead of looking at the sickest of the sick, they look at the health in the community.

DR. VINCENT J. FELITTI: Those who are on the verge of getting sick, who haven't gotten there yet.

DR. JEAN CAMPBELL: And the resiliency, you know, like I think SAMHSA at one point supported an initiative around resilience, I remember. I meant there are like these strains of this that cords through the history and that are in SAMHSA's past where they have gone in that direction -- the resiliency, the committee on -- there's even a book that was published on resiliency that was very good.

DR. VINCENT J. FELITTI: Emmy Werner's book probably.

DR. JEAN CAMPBELL: Yeah.

DR. VINCENT J. FELITTI: Well, what we do now, it seems to me, at its best is kind and good and interesting, and you learn a great deal from doing it. But it keeps you perhaps conferencing so busy that we never really notice that we're just nibbling at the edges of the problem. I mean, what about the tens of millions of people that we're not capable of dealing with? And there will never be resources for dealing with those, given what we know now.

So what we're verging on is really talking about primary prevention. And I'd like to suggest that, you know, a goal of SAMHSA of the future would be really to take this issue on. What would that look like, primary prevention? How would one do it?

And I suspect it would involve using techniques that we have no familiarity with because you're really talking about tens of millions of people, and there are only two vehicles for approaching that many people. One is broadcast television, and the other is the Internet.

Certainly what we're doing now on an individual or small group business -- basis is interesting, appropriate for those people, sometimes effective, et cetera. But it really misses the magnitude of the problem.

MS. PAMELA S. HYDE: Yes, actually, I just saw some metrics this week on our social media work because, frankly, SAMHSA has only been in the social media world big time in the last 3 years. And just if you look at the trajectory, just on Twitter, just take that one platform, it kind of was flat through the first year that we started doing much of it. It went up a little bit the second year, and now it has just exploded.

Now whether or not that's because we're more comfortable with it, or people are finally understanding that we're doing it. Or whether it's because of the last 6, 8 months attention on mental health, I mean, who knows exactly why. But we are now in the middle of the pack in terms of the agencies in the Federal -- in HHS in terms of Twitter followers.

So we are above the Secretary. We are sort of equal with FDA and CMS. We're not anywhere near NIH yet, or what's the other really big one? I've forgotten what the other really big one is. But anyway, we are sort of in the middle of the pack. And if you -- oh, I think we're about even with CDC, too. Or either that or they may be one of the bigger ones yet. I can't remember.

But anyway, it doesn't have anything to do with size. It has to do with whoever -- we have followers. So we have like 32,000 followers now on Twitter, and that is up from 7,000 just a year ago, a year and a half ago. So --

DR. JEAN CAMPBELL: But you know what you don't do which would really help in terms of raising the visibility of SAMHSA, whatever its core mission turns out to be in the future, is something that I recommended earlier for a conference that really looked interesting on violence. That is to directly stream the conference to begin with on the Internet. And then second is to have live Twitter following.

That's what PCORI does, is that they stream live their conferences. And then you can participate by there is this big -- you know, you can throw questions in, and somebody makes a comment, and other people, you know, respond. And people actually at the conference are responding as well. But it makes it inclusive throughout the Nation so it can become a dialogue as well.

MS. PAMELA S. HYDE: Yeah. I think we are sticking our waters -- or our toes into that water, but you're right. We're not 100 percent there yet.

DR. JEAN CAMPBELL: Well, you know, PCORI does it. So I'm suggesting talk to them about --

MS. PAMELA S. HYDE: Yeah.

DR. JEAN CAMPBELL: But if you have people that -- you're in the middle now. So you have people familiar with Twitter that could, you know, attend a conference and, you know, Twitter stuff.

MS. PAMELA S. HYDE: Yeah.

DR. JEAN CAMPBELL: But creating on the Web page the live feed where the comments would -- the Twitter comments would go, they could -- they could probably help you with that.

MS. PAMELA S. HYDE: Yeah, good point. I mean, it's not anywhere near what you were suggesting exactly, but it is to say that we are starting to think more about our capacity in social media or our capacity to reach lots and lots of people. I think the question becomes, again, I throw it back to you because we're talking about this primary prevention, wellness stuff. I think everybody knows that you do have to have information, but it's not enough.

DR. VINCENT J. FELITTI: The biggest public health advance that I can conceive of at this point would be to figure out how to improve parenting skills across the Nation.

DR. CAROLE WARSHAW: Yes. That would be big.

DR. VINCENT J. FELITTI: And the low-hanging fruit for that would be that enormous number of people who grew up in households where there was no experience with supportive parenting, many of whom are volunteering for the military, seeing that correctly as the analog, as a metaphor for a supportive family, which has a great deal to do with why there are such high suicide rates there.

So if one could figure out how to do that, and my thought is that the low-hanging fruit is that huge number of people with no experience personally with supportive parenting, many of whom might do better if they only knew what it looked like.

MS. PAMELA S. HYDE: Point well taken.

DR. VINCENT J. FELITTI: Which raises the issue, could one covertly teach through a serial program on broadcast television?

DR. JEAN CAMPBELL: Well, I also think of the initiative also that SAMHSA did

a few years ago, Dare to Vision, around women and violence and really created a dialogue around women and violence. And just the title "Dare to Vision" created that challenge, I mean, and that's also in our repository. But that's a wonderful model.

And if that conference had been live fed with Twitter responses and people, that would have -- it's like a jump-start, you know, around these important issues that really strike at the heart.

MS. PAMELA S. HYDE: The time that we -- this year, for the first time, we did with the Children's Mental Health Awareness Day, we did that day a live Twitter feed and then a Twitter chat that afternoon. It was -- we had thousands of people. And normally in the past, we'd have 300 or 400 in the -- in the auditorium, and then a certain number of people, maybe up to 1,000, would look at it later. But this year, we got I think there was like 3,000 people for the event itself, and then we had that afternoon 3,000 or so, 3,000 to 4,000. And then, obviously, when people relook, we were approaching 7,000, 8,000 people.

So, yeah, that's what I meant by we're just putting our toe into that water and really have to do that stuff. So a couple more comments, and then I want to ask you a different question. Yeah?

DR. SHELLY F. GREENFIELD: So just in thinking, let me try sort of a related but maybe slightly different paradigm for a future SAMHSA. If you think about SAMHSA as being sort of the organization that represents behavioral health and you think about it as a public health organization, it does seem to me that one mission could be that SAMHSA really be the organization that really is the expert in translation of the evidence into practice for behavioral health, for the health of the public.

You know, in other words, there is no other voice that's really going to be speaking, that I can think of, comprehensively about the fact that we now have 25-plus years of great evidence-based treatments. It's always a paradox to me in the healthcare system that we could now have as many things to offer people as we do, and yet we fail to offer it to them.

And when we do that, we basically -- whether it's on the prevention end, the early intervention end, the screening end, the treatment end, the recovery end, long-term rehabilitative end, we have so much data at this point, so much. And yet most people are still not aware of that. It's really not out there. So if you think about the overall health of the public and the fact that if you really want the public to be healthy, we really need the translation of all this evidence into practice, and you know, it's not there.

And this is the organization, as far as I can tell, that really speaks to, you know, mental health and substance abuse, behavioral health, whichever terminology

we want to use, and in terms of actually doing that translation into practice. And to me, you know, that's a big job in terms of how to integrate that overarchingly in a public health vision and what we're going to do.

And then just back to your point about the economics and the social determinants, you know, in various economics and areas there's a lot of talk about human capital. It's a way that I think economists can begin to conceptualize sometimes the economic impact of making these investments in healthcare, which is it's an investment in human capital, so to speak. And you know, that's sort of what public health is. It's overarchingly that investment.

And I think we have a lot to say to the rest of the healthcare system about all of these things that have clearly been demonstrated to be effective over and over and over again. Not once, so --

MS. PAMELA S. HYDE: Yeah. So let me just a quick reaction, and then I know you had your hand up again. Interestingly enough, the institutes -- the National Institute of Mental Health, the National Institute of Drug Abuse, NIAAA somewhat, maybe slightly less just because their infrastructure is less, but NIDA and NIMH are explicitly working in trying to translate to practice on things like their RASE program or the early psychosis program or first break psychosis program, or the NIDA is trying to just look at substance abuse treatments, things, and how to get them into practice.

Now they talk to us about them, and we share some funding of TA centers and stuff. But it is interesting that the institutes are kind of moving a little bit more into that than they used to. And in fact, Francis Collins, the head of the NIH, has a whole new initiative on translation. So they're actually putting together a whole center just on what's the science of how you translate.

DR. SHELLY F. GREENFIELD: And I think that's right, and I think that institutes -- and as a grantee of those institutes, I agree, you know, in that treatment end of it. But what I would say is that often that is sort of the science of how to translate, but it's not necessarily the scale-up implementation.

DR. VELMA MCBRIDE MURRY: It's the dissemination and diffusion.

DR. SHELLY F. GREENFIELD: So, and the dissemination. And so, you know, it's really -- I mean, what NIDA and NIAAA, the efforts there are great. They are tremendous. And I'm part of the Clinical Trials Network at NIDA. So this is really -- it's excellent work that's being done, and many, many people across the country who are engaged both in the community programs and also in the research end.

But again, once that's done, then the issue is what's the diffusion, dissemination, and the scale-up? And that's the next --

DR. VELMA MCBRIDE MURRY: Exactly. That's the missing piece.

DR. SHELLY F. GREENFIELD: That's the next piece of that, and I'm not sure where -- you know, who's doing that, you know? And right now, that seems like a big job to me.

MS. PAMELA S. HYDE: Well, yeah, and staying true to what the research actually tells you to do while you scale up is a whole other ball of wax.

DR. CAROLE WARSHAW: And having the skills and the capacity to actually implement the things that are evidence based. Because the workforce doesn't necessarily have them.

MS. PAMELA S. HYDE: Yes, actually, we were talking. You're going to meet tomorrow our new Chief Medical Officer, who is going to lead a panel on clinical issues and SAMHSA's -- the role of SAMHSA in clinical issues. And because she's new to us, and we haven't emphasized that as much in our advisory councils. So we're going to do that tomorrow to see what you all think.

And then, but we were talking the other day and talking about evidence-based practices. For example, counseling types. So, frankly, there's lots of pretty good evidence that says a practitioner might say I'm doing cognitive behavioral therapy. But then when you interview the person who just got that counseling, just literally as they walk out the door, and you ask them questions to see what happened in the session to see if any of the elements of cognitive behavioral therapy really happened in there, the disconnect between the workforce saying "I'm doing this" and the person receiving the treatment saying "I experienced this" are two different things. So --

DR. CAROLE WARSHAW: And then how much the relationship matters.

MS. PAMELA S. HYDE: Yeah.

DR. CAROLE WARSHAW: And then doing trauma-informed more, just to have that awareness to do that.

MS. PAMELA S. HYDE: Right, yeah.

DR. CAROLE WARSHAW: People don't have it.

MS. PAMELA S. HYDE: Yeah, so it's one thing to -- it's sort of like back to it's one thing to train the workforce on what cognitive behavioral therapy, to use that example, is. It's another thing to help them make sure they know how to do it. I don't think we've invested nearly enough in the clinical world.

DR. CAROLE WARSHAW: In the supervision. That's what people need.

MS. PAMELA S. HYDE: And the supervision issue, yeah, I think that's right.

DR. CAROLE WARSHAW: And just if the resources aren't there for that, that's --

MS. PAMELA S. HYDE: Okay. So there were other -- yeah?

MS. STARLEEN SCOTT ROBBINS: Well, just one part about the evidence-based practice is this, you know, you do this training once, and somebody is supposedly able to walk away and be the expert in it. And we know, through implementation science, that it just doesn't work that way. And if you don't have that ongoing reupping of training and supervision and technical assistance, that that doesn't work.

But I'm sitting here thinking about cost-benefit analysis. So my boss said to me, well, tell me why women's treatment is worth it. And so, I sit with my program evaluator, and we come up with all of these cost offsets. You know, when you treat a pregnant woman who has an addiction, it's her health, the baby's health, criminal justice, child welfare. The cost-benefit analysis to every other agency that we are talking about, everybody benefits from treating mental health and substance abuse, the whole system.

So I think that as a core, you know, we talk about treating obesity. So there are cost-benefit analysis, but not like there is if you treat mental health and substance abuse. It kind of spreads over everybody else's territory and saves everybody money because this does eventually come down to the dollar. So I --

MS. PAMELA S. HYDE: Speaking of the dollar, if I can use that opening, I said after a couple more comments, I wanted to ask you another question is we haven't been following the questions specifically, which is just fine. But part of the -- part of the issue here is anytime you talk about the future of anything, but in this case SAMHSA's future, what the SAMHSA of the future should look like, it sort of by definition says what would you stop doing in order to do new things or different things?

And inevitably, when you have these kind of conversations, people have terrific ideas on more we should be doing. Nobody ever really wants to cross the bridge with us about what should we stop doing. We did an exercise a couple years ago because we were in a budget cut scenario. We got all the stakeholders in the room. We said, look, we know you're not going to say in front of each other what we should stop funding. So we're going to give you a 3-by-5 card. We want you to write it. You don't even have to put your name on it. But leave it with us at the end of the day.

It was fascinating because what they said we should stop doing was that we should hire less staff. Well, we're already pretty slim on staff, compared to what we do. And if we want to do literally a lot of the things that you're talking about, you're not talking about a whole bunch more grant programs, you're talking about more staff to do things. And then they also said once in a while they'd pick out a grant program and say you could do less of that, but it was in one or two of those. That was rare. But when they did that, it was something that the chair of the Finance Committee personally was in favor of or something.

So what would you say, of all the things you know SAMHSA does, and in terms of functions, if you look at the middle bullet, those are our functions. So we do provide leadership and voice. That's not free, though. It takes time. It takes resources. It takes money to produce things. It takes, frankly, time and effort to get through clearance processes and all that kind of stuff.

Surveillance and reporting. We do tons of that, and it is the data that lets us make statements about what things are out there. For example, our NREPP program, which is the evidence-based practice registry, is backed up because we don't have enough money to send more. It's not like we just -- it's not like it doesn't cost money to vet one of those programs. It does.

And then setting standards and regs. That takes money and resources and science that we have to go look at. Providing information to the public. While social media makes it cheaper per person, it's still not cheap. I mean, still we have to do it.

And then the grant making, providing funding to States, tribes, et cetera, which is being cut some by the sequester. It's not hugely yet, but if it keeps going it will be. Right now, it's just a few less grants. But eventually, that's going to be more than just a few less grants.

So, given those functions and given, you know, the other things that we do or focus on or whatever, where would you say, you know, really in order to do these new things you talked about -- these are really rich ideas -- what would we do a little less of from your perspective?

DR. CAROLE WARSHAW: Well, one question I have is with the block grants and how that's going to change with the ACA, or if some of that money -- I know you can't really -- you don't have control over what the States do. But I'm thinking about some of the public mental health kind of things. Could the block grant be targeted in ways that address some of the newer ideas?

MS. PAMELA S. HYDE: Well, it's a good question. We get asked that question a lot by Congress and OMB and other people. So we're trying to respond to that. The States, of course, feel like it supports the basic infrastructure of providers out there, but that's a great question.

DR. JEAN CAMPBELL: Yeah, I would think scalability of evidence-based practices is a good place for block grant money to be spent, and I just don't think the dollars are being spent in that area in a lot of the States. It's basic services instead of evidence-based services.

DR. VELMA MCBRIDE MURRY: So I guess a report today was saying 18 percent of the programs offered or treatment plans were evidence based. Some report we heard today.

MS. STARLEEN SCOTT ROBBINS: On the mental health side, right?

DR. JEAN CAMPBELL: Yeah.

DR. VELMA MCBRIDE MURRY: Yeah, the mental health side.

MS. PAMELA S. HYDE: Do you know who said that?

DR. VELMA MCBRIDE MURRY: There was a report from the mental health block grant.

DR. JEAN CAMPBELL: I don't even know.

MS. PAMELA S. HYDE: I don't know how anybody would know that information.

MS. DEBORAH BALDWIN: We actually do track -- we have been tracking the number of clients served in evidence-based services through --

DR. JEAN CAMPBELL: That was for women, the 18 percent.

DR. VELMA MCBRIDE MURRY: For women.

MS. DEBORAH BALDWIN: Just for women.

MS. PAMELA S. HYDE: Oh, I was going to say.

DR. VELMA MCBRIDE MURRY: Women.

MS. PAMELA S. HYDE: Oh, I thought you meant the whole thing.

DR. VELMA MCBRIDE MURRY: No, for women.

[Laughter.]

DR. VELMA MCBRIDE MURRY: But for women, but 18 percent, and it's like why wouldn't we require --

DR. JEAN CAMPBELL: Yeah, exactly.

DR. VELMA MCBRIDE MURRY: -- it to be this is what you use.

MS. PAMELA S. HYDE: Well, now, interestingly -- I'm sorry. Go ahead, Johanna. You were starting. Jump in.

MS. JOHANNA BERGAN: They're not right. Hi, everybody. They don't cover it all.

MS. PAMELA S. HYDE: Right, right, right. Right. You don't want to just limit it.

MS. JOHANNA BERGAN: Yeah, yeah.

MS. PAMELA S. HYDE: Because there's a lot of gaps in the evidence is a big issue.

MS. JOHANNA BERGAN: There are populations that wouldn't be served by anything.

DR. VELMA MCBRIDE MURRY: It suggests then -- I mean, having a large catalog of programs.

DR. JEAN CAMPBELL: Yeah, there's NREPP, too, you know, in addition to the official evidence-based practices. But reconceptualizing the block grant not to just fill all the --

DR. VELMA MCBRIDE MURRY: There's use for --

DR. JEAN CAMPBELL: All the gaps, you know, for States that turn down the Medicaid money, and then you fill more gaps there. And I just think that consistent with, I hate to say the word, the new Freedom Commission. But that, the whole point was to deliver effective services. And so, I think a more targeted approach with the money in the States.

You know, they don't know still to this day whether, you know, it's the first money spent or the last money spent. It's not really clear, because those funds intermingle, where the focus in the States are. I mean, it's ill-defined, and I would say spend the money on the types of things that we've identified here as things to add. That would be a place to do it.

MS. PAMELA S. HYDE: Did you guys see the 2014 President's budget? You know, these budgets haven't gotten nearly as much play as they normally do because Congress hasn't passed a budget in so long. But in that, there was a new set-aside in the block grants to allow or require States, and it was a little

different in substance abuse and mental health, but to require States to use a certain portion of the money for enrollment and eligibility. The theory being if you're going to have other people covering some of these services and you've got to be able to spend a little money to do that.

But then also to do on the mental health side, to do evidence-based prevention and treatment services. And obviously, the States say come on. You know, there's only -- because it's --

DR. CAROLE WARSHAW: It's not enough money.

MS. PAMELA S. HYDE: It's not enough. Yeah, it's not like they don't want to do that. It's just that they say the administrative infrastructure to try to track the money in that way. And OMB, God love them, wanted us to do it in a full-scale, competitive approach. So it's like one more. You know, it costs money to do a competition.

So, anyway. So at least it was, again, a toe in the water about that. States had some concerns about it, and I don't think it's getting much discussion on the Hill because '14 is all up in the air with all this discussion about budget. But anyway, I don't know if you think that was a good idea or the right way to try to approach this, or if you can think of another way to do it.

DR. JEAN CAMPBELL: Well, it's not enough money.

MS. PAMELA S. HYDE: Yeah. Half a billion dollars for the whole country is not -- it's a drop in the bucket. And for some States, it's like 1 percent of their money. I mean, it's just like it's not enough money to have the Federal Government, you know, wave a threat over your head and say do it this way or you don't get the money.

DR. VELMA MCBRIDE MURRY: I have a question in response to your question to us. As we look at the focus of SAMHSA in terms of mission and vision and in light of our conversation, are there any of these that can be utilized for the purposes of expanding SAMHSA into a public health? I mean, would it further the mission if we think of SAMHSA as a public health institution? What is it about any of these then would fall off? And it may be that it begins to fall off because it doesn't directly address this exciting mission that we're talking about.

And then a second question is which of these really provide the greatest impact for the investment?

MS. PAMELA S. HYDE: All good questions.

DR. VELMA MCBRIDE MURRY: All of it.

[Laughter.]

MS. PAMELA S. HYDE: You tell me. You're advising me.

DR. VELMA MCBRIDE MURRY: I'm advising.

MS. PAMELA S. HYDE: I always say, and you'll hear me say it tomorrow, advice is a product. Giving us your wisdom.

DR. SHELLY F. GREENFIELD: Can I just -- you know, you were talking about just the difficulty of, you know, of accomplishing mission in the face of constrained budget, which is just, you know, kind of a rampant problem no matter where you're living at the moment.

MS. PAMELA S. HYDE: Yeah, that's right.

DR. SHELLY F. GREENFIELD: So, you know, I was just thinking that, you know, it's not a small matter, though, how you conceptualize the agency. Because in a way in conceptualizing what the mission is, it also enables you to partner with some of the other agencies around that same mission.

Because you were just mentioning some of the research institutes that are doing some of the translational work where they can't scale it up, you know? You could imagine in some ways if your mission is in the service of the public health, facilitating a continuum of care all the way across from, you know, primary prevention all the way through, you know, recovery for behavioral health. You can imagine sort of saying in that mission we partner with, you know, so and so and so and so, who are providing the research around such and such. But our piece of what we're doing is to take that and move that toward scalability, you know, in, you know, 10 States, or whatever it is, you know?

So not thinking that you're going to accomplish all the pieces of it. But in -- so it doesn't seem like a small matter how you conceptualize, you know?

MS. PAMELA S. HYDE: Yeah. Not at all.

DR. SHELLY F. GREENFIELD: Because it does enable you to make those partnerships with the other, you know, agencies that exist to accomplish the mission, you know? So that's just one other thought.

DR. CAROLE WARSHAW: And maybe it's a way of being the uber kind of -- you know, the agency that really thinks about all of this and how it moves into practice and what's the state of the art for each of these areas and, you know, what are we taking from research. What are we learning from the field? What are we learning from groups that have been marginalized? How do we put that together? How do we move -- you know, providing that kind of guidance that

includes the three kinds of evidence, you know, the research based, the practice based, and the contextual.

Like, I mean, CDC is the model, but maybe SAMHSA is doing it for mental health and substance abuse and prevention and well-being, you know, that kind of continuum of -- because the interests of SAMHSA, it's not the primary interests of anyplace else.

DR. VELMA MCBRIDE MURRY: This whole notion of scalability and moving into the other end of the continuum of research to translation is -- it's not held any place.

DR. SHELLY F. GREENFIELD: Right. I think it isn't.

DR. VELMA MCBRIDE MURRY: No one is -- no one is the expert, a national voice of how you do it, and so --

MS. PAMELA S. HYDE: So it sounds -- if I took these comments and tried to translate them into the question that I think you asked, Shelly, or whoever it was, Starleen, which would you do more and which would you do less -- somebody down at that end.

[Laughter.]

MS. PAMELA S. HYDE: It sounds to me like you would say that we should be providing more leadership and voice and that we should be doing more improving practice kind of thing and maybe setting standards.

DR. VELMA MCBRIDE MURRY: Setting standards.

MS. PAMELA S. HYDE: But, and maybe more providing information to the public and the field. And certainly, I mean, you could sort of anticipate -- you could conceptualize a grant program about parent training, for example, or parent skills building. But it's not so much more grant making as it is more of these other functions as well.

DR. JEAN CAMPBELL: Yes. Some of the grants, unless they focus on what the initiatives that are identified, are the key ones to help achieve the vision.

MS. STARLEEN SCOTT ROBBINS: And improving the practice, and improving the practice, you are setting the standard. So, I mean, in some ways, you know, putting more focus in that area will kind of feed some of the other things that are happening, and you actually might have to take less energy in those areas because you would be actually developing the standard as you're improving the practice.

DR. JEAN CAMPBELL: Plus, the standards can be set by professional organizations in collaboration.

MS. STARLEEN SCOTT ROBBINS: Right.

DR. JEAN CAMPBELL: So I've been thinking about who else can help promote our agenda.

MS. HARRIET C. FORMAN: Harriet. In some of the cases, the partnering with other agencies. For example, if you're talking about parenting, education is a close place to be partnering because certainly the whole field of education, you've got -- you've got a natural partner where the coming together, working together is, you know --

DR. CAROLE WARSHAW: But you also have NCTSN already that's doing a lot of work in that area now with some of the --

MS. PAMELA S. HYDE: Yeah. Yeah, you know, it's funny because SAMHSA does a little bit or a lot in a lot of things, and it is -- it is one of our challenges is whether or not to, you know, say there's 100 things and we're doing all 100 of them a little, or to say now we're only going to do 50, but we're going to do them a lot better or bigger or whatever.

And then, obviously, there is a whole stakeholder ownership on every single little program. Even if it's only $2 million, there's a whole organization of stakeholders out there that care about that. So, for example, SAMHSA, SAMHSA's budget really reflects congressional -- at least congressional staff, if not congressional leaders because, frankly, I want to be honest about it, staff put together the budgets. It really reflects their belief and, frankly, to some extent OMB's belief that more grants are better. So the more grants the better, and don't cut any existing grants.

DR. CAROLE WARSHAW: Because of constituencies?

MS. PAMELA S. HYDE: I don't know if it's a philosophy or if it's that. It could be some of both. But I think in Congress certainly there's, you know, 50 States plus. So to the extent that there are stakeholders in Congress, namely Representatives and Senators who need to go back to their communities and say you have an opportunity for this grant. You can -- you know, I voted for something that would let you have an opportunity for this money.

Now you would think that would translate to things like protecting the block grant because all 50 States would get it. We found that it didn't. It was much more we found in a sense that, not in an evidence-based sense. But in the sense of we tried at one point to protect the block grants because we thought it was the basic infrastructure out there for the community -- or for the system, and Congress

didn't seem to be all that interested in helping to do it.

Now when the constituencies went in and tried to maintain or grow the block grants, they had much better luck at it than we did. But when we're talking to them, they just want to know how many more grants are you going to be able to give, and don't cut that program because it's going to reduce grants by X number or whatever.

DR. CAROLE WARSHAW: So they don't care about public mental health?

MS. PAMELA S. HYDE: Well, they -- I don't know that they don't care about it. I think it's they don't see SAMHSA that way. They see us as we're the ones who are giving their constituencies grants, and that matters to people. So we fight that a little bit, and I don't mean fight in the sense of it's a knock-down, drag-out. I mean, we care about our grants, and we care about the way we use our grants to be strategic, as you're talking.

I don't know if -- this group surely has seen the theory of change arrow at one point or another. Since Kana helped draw it, I can't imagine that you didn't see it. So we've been thinking for a long time about this issue, about how do we make sure our grants are not just to help the community where the grant is for the 3 years they have it, but really helps us learn something for the field and then move things to the field. So we've got this trajectory we think about.

But Congress seems to think about just more grants is better, especially in an area that they care about. And we tried -- we've tried to set some priorities. So we've tried to say things, and you may or may not agree with this. But we've tried to say, look, we're not going to go more heavily. We already -- we have a little bit in the area of aging, but not a lot. But we're not going to go more heavily in that because there's a whole Administration on Aging, and that's what they do. And frankly, they're much more covered by treatment services and other things than other populations.

We're going to help them. So we gave them a little bit of money at one point to help them do prescription drug abuse prevention and suicide prevention, and it really helped them a lot. But we don't do a whole lot more about senior stuff. But I get pushed a lot to do things across the life span, and I keep saying, no, we're going to focus on the populations that we have more ability to impact because there's a whole other group over here who does aging, and we're going to partner with them to give them expertise or whatever.

Now one could argue there's a whole Administration on Children and Families, but we do a ton of work in children, and we've been very successful, I think, in giving them information, models. Like I said, really our trauma work, they have just embraced big time, and now they're running with it. So I guess you could make the same argument the other way is maybe we shouldn't do as much there

because they are.

But the way we chose to do it was we've learned something in 10 or 12 years. Let's translate it to them, if you will, or give it to them and let them grow it in their system. So --

DR. JEAN CAMPBELL: Well, wouldn't your vision help dictate where you would spend your money? So I meant once you have this focus on public health, particularly prevention and wellness, as well as --

MS. PAMELA S. HYDE: Yeah, yeah.

DR. JEAN CAMPBELL: -- clinical, then you can make a determination about I remember we'd had a couple of suggestions, and those might be the ones, where you want to start.

MS. PAMELA S. HYDE: Right. Well, and to the extent that we -- that the IOM data tells us that about half of adult mental health issues start before the age of 14 and about three-quarters of them before 24. So we have totally in the last 4 years anyway, and maybe before that as well, but we've totally focused on young people, early childhood, prevention --

DR. JEAN CAMPBELL: But you haven't done it with this dialogue, with this --

MS. PAMELA S. HYDE: Not in this context, but we've done it with our --

DR. JEAN CAMPBELL: Trying to help develop the message as well as the branding.

MS. PAMELA S. HYDE: Yeah. Yeah, and I think we're just really just now getting into the support of youth recovery, which doesn't mean we haven't done some of it. But in terms of really trying to lift it up as a place that people can jump onto.

So -- so we have about 15 minutes left. I don't know if you feel like we've gotten through some of these --

DR. JEAN CAMPBELL: I had an idea about the workforce, the workforce issue --

MS. PAMELA S. HYDE: Yeah?

DR. JEAN CAMPBELL: -- with SAMHSA. And it relates to the last piece about developing this culture of public health and focusing on wellness and recovery. So I think that that could be -- in order to change the culture here of people so they think about things in a new way, you know, get out of the box, doesn't mean

you're going to change a lot of the stuff you're doing. You're just going to think about it in a different way and come to different conclusions, is to have some sort of professional development initiative if you decided around public health, you know, in the concepts of public health.

And also identify people that are knowledgeable about that to be mentors to their -- to their colleagues, and I would also suggest that you think about bringing in young people to do internships, particular --

MS. PAMELA S. HYDE: We do do quite a bit of that, but probably we could do more. Yeah.

DR. JEAN CAMPBELL: And -- well, it just brings such a strength, like I don't see an intern in here.

MS. PAMELA S. HYDE: Just a lot of them just left. They literally just left last week because they're often summer interns out of college, in between college.

DR. JEAN CAMPBELL: And I would see recruiting peers, you know, young peers as well in the 18- to 24-year-old age group that would provide, you know, not only -- because I think that sometimes we just get tired.

[Laughter.]

DR. JEAN CAMPBELL: Or we lose the enthusiasm. And I've had interns and people that I have been mentoring, young investigators and stuff. And sometimes they lift me up and say let's -- let's go train those consumers to be interviewers. And I'd say, oh, let's just go get some students to do that.

That, yeah, I think that they bring that energy and hopefulness back to the field, which sometimes I think we lose late in the afternoon.

[Laughter.]

MS. PAMELA S. HYDE: Well, I do want to get -- because Johanna is going to be the report-out, right?

MS. JOHANNA BERGAN: Yeah, I don't know what I'm going to say.

MS. PAMELA S. HYDE: Yeah, we need to spend a minute or two on what you want Johanna to say.

DR. SHELLY F. GREENFIELD: I was just going to -- I just -- SAMHSA does do the National Survey of Drug Use and Health.

MS. PAMELA S. HYDE: Yeah.

DR. SHELLY F. GREENFIELD: I just want to say that I think that's incredibly valuable to the field, and that is one thing that I think, you know, really I hope will continue on. And I would say that, you know, there are many already-existing strengths and programs that the agency has, and that would be one of them, and I think that is -- that's one platform. I just know that when people are looking for information, that's often the best source of current, this past year information. I mean, because it's not collected often anywhere else.

So, you know, one thing there is in this changing environment, that tool could be utilized to provide, you know, additional questions on services utilization or gaps or things that, you know, you might wish to know in terms of how are we doing around translating the evidence into practice. Who's getting what, why, when? It just seems to me that that's an incredibly powerful tool that you're already doing -- you're already doing it. You can tweak it in a way that could actually leverage some of the other agencies' programs even to be focusing more.

So I just wanted to -- as you're thinking about the SAMHSA of the future, I just want to, you know, reassert that that's a very, very important, I think, service that the agency provides to the entire system.

MS. PAMELA S. HYDE: That's good to know, and you should know that when we moved the Office of Applied Studies into the Center for Behavioral Health Statistics and Quality, it's been now about 2 1/2 years. It's really just now starting to come into its own as a center because we really want to move beyond doing our own surveillance. That is definitely something we want to continue.

But we also want to be able to use other data sources. You know how CDC will put out its MMWRs? They don't -- frankly, a lot of that is our data. I mean, not all of it, but about mental health and substance abuse, a lot of it is our data. But they put it together with other data and make a report out of it that gets attention because they're CDC. And that's cool. We feed them stuff to do that.

DR. SHELLY F. GREENFIELD: Right.

MS. PAMELA S. HYDE: But we're about to put out a barometer. It's not cleared yet. I'm hoping we don't run into problems with clearance because it's mostly data from sources that are already out there, but we're trying to package it so that there will be a national one and then one for every 50 States. I'll talk about this tomorrow.

And the idea is to do a snapshot at a point in time, but we want to do it regularly, like every year, hopefully, in which we take data that's already out there, but somebody would have to put it together in six different ways. And when we were putting it together, this first time out is fairly rudimentary in the sense that we're using our data, two or three other funding sources that we can easily put our

hands on. But trying to create a snapshot of behavioral health in the country on any given moment, and then we can watch it over time.

So we're real excited about that, but we're just -- you know, you never know when you put something new through clearance what will come back.

DR. JEAN CAMPBELL: So we're going to have a barometer on well-being?

MS. PAMELA S. HYDE: Well, right now, what we have the ability to do is a barometer on what the data is that we have. So we have how much substance abuse, how much this, that, and the other. So there are survey -- it's not ours and it's not easy. But there are stuff now about measuring happiness, measuring sense of well-being, et cetera. So, frankly, most things are proxies for that, as you well know because you guys are better data geeks than I am.

So there's not a simple kind of, you know, set of data for the wellness of the country sort of thing. So, anyway. All right. So we're going to run out of time.

Yes, Johanna?

MS. JOHANNA BERGAN: Yeah.

DR. VELMA MCBRIDE MURRY: Can I just say this one thing, and then it will be short. But it is, as you mentioned this report that SAMHSA is planning to release if it goes through clearance?

MS. PAMELA S. HYDE: The barometer, yeah.

DR. VELMA MCBRIDE MURRY: It may provide an opportunity as a pivotal transition for image building because SAMHSA is so nice. You know, we play very well in the sandbox and just let other people really take the ball. So it's now a way to use the ball that we've been giving other people and begin to really elevate and think about a pivotal transition for the image of SAMHSA.

MS. PAMELA S. HYDE: Yeah, you raise -- you raise in that statement a tension that we struggle with all the time, which is how much of it do we say, no, it's our ball, dang it.

DR. VELMA MCBRIDE MURRY: Yeah, yeah.

MS. PAMELA S. HYDE: And how much do we say, here, have the ball. You know, we brought it to the party, but have the ball.

DR. VELMA MCBRIDE MURRY: What I think is that, you know, as we've been talking today --

MS. PAMELA S. HYDE: We try to do a little bit of both.

DR. VELMA MCBRIDE MURRY: Yeah, and it's great. But elevate a little bit more in terms of the position and status of SAMHSA because it has it.

MS. PAMELA S. HYDE: Well, and as we help Johanna -- I'll make a final comment here, but also as we help her think about what she's going to say tomorrow, I also just want to say I know you have injected in a few of your comments things specifically about women and girls. But I don't know that our conversation has been explicitly about that.

So to the extent that you have any final comments about that, it would be good to know as well. So do you have a comment or --

MS. JOHANNA BERGAN: I do have a comment.

MS. PAMELA S. HYDE: Okay.

MS. JOHANNA BERGAN: So I was thinking about in the mission and vision, A, providing leadership and voice. And I think we've ascertained that we think that that's valuable. And I have just been thinking that, yes, it's valuable. Social media is great. You're doing amazing things on Twitter.

MS. PAMELA S. HYDE: Starting to.

MS. JOHANNA BERGAN: Because we have a lot of content, right? SAMHSA has information, and that's what makes you good in social media. You have a lot to offer. And so, but I'd like to also think about limiting budgets and moving forward. How could SAMHSA provide leadership and voice at the organizational and institution level rather than the individual population of the United States?

So let -- let somebody else educate us as individuals, but can SAMHSA work with bigger fish to make sure that mental health and substance abuse is in every conversation? And so, in my community, we have a 9-year funded food and fitness initiative by W.K. Kellogg. Awesome, right? It's youth driven. It has family voice. It has all the partners. Mental health isn't at the table. And it should be.

Every time I come to the meeting, I'm like we're missing someone. We're actually helping them out. We're servicing and supporting our young people in ways that they can't because they don't have the money. Let's get them at the table so we can all count the impact of what we're doing.

MS. PAMELA S. HYDE: Yeah.

MS. JOHANNA BERGAN: So if SAMHSA works -- so the big fish understand to

pass through in all of their little initiatives that behavioral health needs to be part of the community conversation.

MS. PAMELA S. HYDE: That's a great point because we've spent a lot of time teaching math and reading skills. We spend increasingly amounts of time teaching, you know, basketball and soccer and hockey skills.

MS. JOHANNA BERGAN: Yeah.

MS. PAMELA S. HYDE: And we are now increasingly starting to train kids on nutrition and health skills. We are not yet really training them on emotional health skills and behavioral health skills.

MS. JOHANNA BERGAN: But we're a step away --

MS. PAMELA S. HYDE: Yeah, we're close.

MS. JOHANNA BERGAN: -- instead of six steps away. So then maybe SAMHSA's job is just -- just to talk to education, and then someone else is going to educate me and my community. It's not going to come from SAMHSA directly.

MS. PAMELA S. HYDE: That's a good point.

MS. JOHANNA BERGAN: Yeah.

MS. PAMELA S. HYDE: So what are we telling -- what's Johanna saying?

MS. JOHANNA BERGAN: What am I saying tomorrow? I have two pages. Maybe I could just read that.

MS. PAMELA S. HYDE: I have only one, but I write little.

MS. JOHANNA BERGAN: You write little. Yeah, I wrote big.

DR. SHELLY F. GREENFIELD: You did want -- you did want a statement, though, from this group about girls and women, and --

MS. PAMELA S. HYDE: Well, it's up to you. We didn't ask like treatment to only talk about treatment. We really put these as generic questions out there.

DR. SHELLY F. GREENFIELD: But I think, you know, it's worth at least having one or two lines here just because we spent the rest of the day really talking about sort of girls and women and treatment and on some of the sort of what feels to be escalating needs, both in terms of the reproductive healthcare rights of girls and women across the country, life span-related issues, the fact that there's increasing substance use problems from earlier ages, and the

overarching health impact of that through the life span.

So, you know, we've -- you know, we've touched on all -- on many of these things earlier in our conversations, and certainly I think that -- I'm not sure that that has a particular home almost any place, necessarily. And for sure the treatment need gap is pretty -- is pretty significant, and I think, you know, I don't know that anybody would wish that to disappear as a priority from the agency. I would think to the complete contrary. So I just --

MS. PAMELA S. HYDE: This is a good place for me to leave you. I'm going to let you have the rest of this conversation because I have a call at 4:00 p.m. that I have to ready for. So you guys figure out what --

DR. VELMA MCBRIDE MURRY: Thank you so much.

DR. SHELLY F. GREENFIELD: Thank you very much.

MS. PAMELA S. HYDE: -- you want to tell the larger group about this conversation. It's been really helpful. I've got tons of notes from all the committees I've been in today, the councils. But you guys always have a rich discussion, and frankly, I don't always get to spend time with you.

So, since Kana is here, I usually go running around other places. So thank you for letting me spend a little time with you.

MS. SHARON AMATETTI: Thank you. Thanks a lot.

I have three pages. So I think I'm the winner.

[Laughter.]

MS. SHARON AMATETTI: But I'm not the reporter. Does anyone want to take a stab, or do you want to, Johanna, first just highlight some of the things that we've already covered so we don't introduce a whole lot of new things and not come to a conclusion?

MS. JOHANNA BERGAN: Nothing new. Okay.

DR. JEAN CAMPBELL: I had a question. I don't know if this is politically incorrect or not. But I was thinking how do we take what we said -- we mainly, except for Vincent, are all women. But the direction of our comments were toward public health, and I was thinking that maybe that isn't by accident that women have particular roles and functions in this society -- and that's the part where I was thinking maybe that was not politically correct -- but that are best addressed with a public health model, and we need programs and services that really is supportive of that.

I think that SAMHSA is positioned to really do a better job. So I think that our -- the needs of women and girls really relates to the recommendation to develop this public health approach.

DR. CAROLE WARSHAW: You know, and I think one of the things is that in probably in this room that we assume we're thinking about women's needs when we're talking about public health needs. But it's not explicit when you talk to other people. It also needs to be explicit.

DR. SHELLY F. GREENFIELD: You're supposed to come up with two big points from us.

MS. SHARON AMATETTI: Her. She's --

DR. SHELLY F. GREENFIELD: We're supposed to help you then articulate the two big points.

MS. JOHANNA BERGAN: So maybe, Carole, it would be important in framing our comments tomorrow very clearly to say where they're coming from and kind of lay out that we are coming from a women's perspective.

DR. VELMA MCBRIDE MURRY: Or maybe that whatever the big statement, two statements are, that the discussion in our group would always be mindful of the importance of girls and women in the context of whatever it is that we're proposing.

MS. SHARON AMATETTI: You had said that it was important for SAMHSA to be mindful about what is our unique contribution.

DR. VELMA MCBRIDE MURRY: Yes.

MS. SHARON AMATETTI: So, and then you can add on to what you had just said. What is our unique contribution, and how can we be mindful of the needs of women and girls or gender-specific needs?

DR. CAROLE WARSHAW: And I think, you know, for SAMHSA, especially on the substance abuse side, having gender-responsive treatment, I don't know of anyone else in the country that does that around anything. I mean, it should be actually part of everything that SAMHSA does, that they are mindful of that and of culture. You know, of like thinking about who services are tailored for and what are the unique needs so that that's part of the picture.

MS. SHARON AMATETTI: For boys and men, as well as women and girls. Just to have a gender lens on the work.

DR. CAROLE WARSHAW: A gender lens, a cultural lens, a trauma lens. There are lenses that SAMHSA has really taken the lead in thinking about this in some areas and that that needs to be part of the work and to keep that going and to expand it.

DR. VELMA MCBRIDE MURRY: You know, I do think that the discussion, while we talked about a lot of things, it seems that we came back to what the strengths of SAMHSA are and the uniqueness of SAMHSA. As Administrator Hyde talked and all of us, you know, it was about what is the history of this organization and how might that be leveraged as this new image is being developed? Because it's really to elevate who we are and what we provide and then take advantage of that rather than giving it away so as there's somebody else claims it.

And it seems that that's what has happened a lot. It's -- yes, I'm sorry.

DR. CAROLE WARSHAW: I'm thinking about what -- I'm building on what you're saying, but I'll wait until you're finished.

DR. VELMA MCBRIDE MURRY: Oh, no, no. That's --

DR. CAROLE WARSHAW: I just got excited.

[Laughter.]

DR. CAROLE WARSHAW: I think that part of what SAMHSA has done is brought voices to the table that aren't usually at the table at a Federal level, and that inclusiveness is really important, and so the tension is like too much consumer, recovery, peer, not enough science. But to really be the kind of bridge or the -- not clearinghouse, but you know that kind of brings together both the science and the practice from the field and voices that aren't always at the table and the lenses that you want to add and finds a way to kind of pull that together and then put it back out and to support practice, support thinking, support policy, you know?

DR. VELMA MCBRIDE MURRY: And that point I think goes to what Shelly was saying about completing this cycle of researched practice and diffusion of scalability. And it's because of our being able to do those things that you just mentioned, Carole, that SAMHSA is the expert --

DR. JEAN CAMPBELL: Exactly.

DR. VELMA MCBRIDE MURRY: -- in order to move translational science to the diffusion and dissemination component or process of the cycle.

DR. CAROLE WARSHAW: But that it goes both ways.

DR. VELMA MCBRIDE MURRY: Yeah, it does. Because it hasn't -- there isn't a home for that. I was sitting here thinking about how difficult it is. I'm at a point of doing implementation research now and trying to find a home in order to get this kind of work funded because I don't know where to take the grant. And then the people that review it don't have a clue about what it is I'm trying to do.

DR. CAROLE WARSHAW: Is AHRQ doing any of that with --

DR. SHELLY F. GREENFIELD: Sort of no.

DR. VELMA MCBRIDE MURRY: Yeah, right. Sort of no.

[Laughter.]

DR. SHELLY F. GREENFIELD: I mean, in pieces, but not in this arena. Not in this arena.

DR. VELMA MCBRIDE MURRY: Not at the place where I think the work needs to be, which is getting these evidence-based programs out in a real-life setting to test their effectiveness once they leave a research setting. And because once we know that, then it can be scaled up.

But I don't know where to -- you know, I've sent it to places, but they look at it like they have no idea how to even --

DR. CAROLE WARSHAW: And what about PCORI? What are --

DR. VELMA MCBRIDE MURRY: PCORI is just -- it's a new funding that's been recently, yeah, and is patient --

DR. JEAN CAMPBELL: They've announced the award of the first.

DR. VELMA MCBRIDE MURRY: Exactly. And it's much more patient oriented.

MS. SHARON AMATETTI: We'll talk about that after the break. So we --

[Crosstalk.]

MS. SHARON AMATETTI: So I'm hearing some themes around unique contribution. SAMHSA could be more mindful about their unique contributions in terms of diffusion and scalability of research which is facilitated by being inclusive of a lot of different partners. Something --

DR. VELMA MCBRIDE MURRY: Oh, Shelly is writing.

DR. SHELLY F. GREENFIELD: I took a couple of stabs at writing it down only

because I can't really think unless I write.

[Laughter.]

DR. SHELLY F. GREENFIELD: A problem, but true.

MS. SHARON AMATETTI: Will you share with us?

DR. SHELLY F. GREENFIELD: Yeah, I just tried -- so this is for tweaking, you know, or revision. So SAMHSA of the future is a public health organization uniquely representing the need for a continuum of services for behavioral health. In representing these needs, it will support/implement the translation of research to practice and diffusion of these evidence-based -- and diffusion and scalability.

And then a second point, SAMHSA can partner with other organizations to leverage resources to accomplish its mission of diffusion of evidence-based practices from primary to prevention, to treatment, to recovery, to facilitate the health of the public.

I don't know. That's just one stab.

DR. JEAN CAMPBELL: But the inclusion of the provider voices, service recipient voices, Federal partners --

DR. CAROLE WARSHAW: And it's also practice to evidence as well. I mean, I think it has to go both ways. It can't just be one way.

DR. VELMA MCBRIDE MURRY: Oh, yes. Oh, yes. One way. Exactly.

DR. CAROLE WARSHAW: Because it's too many gaps in the evidence.

DR. VELMA MCBRIDE MURRY: And then in the context, as the Committee on Women's Services, of course, discussion about gender --

DR. SHELLY F. GREENFIELD: Do you want me to send this to you?

DR. JEAN CAMPBELL: NIMH --

MS. JOHANNA BERGAN: Yeah. And then my only question. Yeah, I think that would be good. So I have a beginning.

[Crosstalk.]

REPORTER: Excuse me. One conversation at a time, please.

MS. SHARON AMATETTI: Yes, please. Please.

DR. VELMA MCBRIDE MURRY: We have other people listening. Our operator says that we have one conversation.

[Crosstalk.]

MS. SHARON AMATETTI: Carole? Carole? Thank you.

MS. JOHANNA BERGAN: So I have a beginning of where this conversation is coming from in terms of from our committee, what Shelly is going to send me. Is in the beginning of what you said, Shelly, do you talk about the value of SAMHSA's many years of listening to consumer experience and bringing all of the varying lenses. And we've listed at least 12, is that in there yet?

DR. SHELLY F. GREENFIELD: It's not yet. So how about if I put down, point one, lenses, and then you will have that?

MS. JOHANNA BERGAN: Yes, and then I have that. Okay.

[Background conversation.]

MS. SHARON AMATETTI: So the diffusion and scalability and inclusiveness were the three main themes, I think, there. Is there another theme that we want to share that's a good -- that would --

DR. VELMA MCBRIDE MURRY: What do we have, three?

DR. JEAN CAMPBELL: Well, we have -- they're sort of one and a long two.

DR. SHELLY F. GREENFIELD: They're kind of related. You could do another, another theme, I think.

MS. SHARON AMATETTI: Something about primary prevention perhaps?

DR. VELMA MCBRIDE MURRY: Vincent's comment.

MS. JOHANNA BERGAN: When Jean started your not quite sure if you were politically correct comment, I was thinking the same thing. So I think we're all on the same point of something about caring for the caretakers theme, and that I think it was prompted by Vincent's conversation of parenting skills and how would we really instill that, and logically, who would we be educating? And mothers seem to be a primary target.

DR. CAROLE WARSHAW: And fathers.

MS. SHARON AMATETTI: Parents.

MS. JOHANNA BERGAN: Parents.

DR. VELMA MCBRIDE MURRY: You mean traditionally or ideally?

MS. JOHANNA BERGAN: No. Oh, not ideally.

DR. VELMA MCBRIDE MURRY: Okay.

MS. JOHANNA BERGAN: Ideally, it would be everybody. I guess I was the reason it comes to mind is because throughout our presentations today, we were identifying where there is language and has been language for the last 20 or 30 years about focusing and emphasis on service for pregnant and mothers with dependents. That focus already exists, and why not maximize its being there?

We wouldn't write it like that again today.

DR. JEAN CAMPBELL: That could be an example of the first statement. It really -- it really is. It has the history. It has the different lenses. It takes credit for what it does well. It's a public health approach.

MS. SHARON AMATETTI: Johanna had a very good observation at the end of our conversation about the voice at the organizational level because unlike many of the other public health agencies who are talking very directly to the public, SAMHSA has often relied upon intermediary organizations, stakeholder groups to do our work. And I think that's a really critical, critical strategy. It has been, and the question is do you all think it should continue to be? And if so, also is there a gender slant to that?

MS. JOHANNA BERGAN: Well, I think Starleen's presentation this afternoon is a superb example of why that works.

DR. CAROLE WARSHAW: So I think doing more of that.

MS. SHARON AMATETTI: So maybe recommend -- make a recommendation along that line.

DR. CAROLE WARSHAW: To look at some of the effectiveness of the Women's Services Network and to expand, use that to expand sort of that kind of --

MS. STARLEEN SCOTT ROBBINS: Kind of the lessons learned.

DR. CAROLE WARSHAW: Yeah, from the mental health side and other side. Right.

MS. STARLEEN SCOTT ROBBINS: Well, because it is not there on the mental health side for women. I can tell you that.

DR. CAROLE WARSHAW: And it needs to be.

MS. STARLEEN SCOTT ROBBINS: And it can be with the right supports in place at the State level and with support from SAMHSA for sure.

DR. CAROLE WARSHAW: I mean, I think in doing, you know, the trauma, social justice initiative, which is still there, which we have it say should stay there, but to also have a gender lens. I would think in everything. Maybe looking at all the -- we didn't talk about all the strategic initiatives and what a gender lens would mean in each of them. Rather than just women's issues, are there places where that would make people think differently?

DR. VELMA MCBRIDE MURRY: I really like this when we talked about the voices at multiple levels, it just shows that SAMHSA has been engaged in community participatory approaches historically. That it's now a new fad or a new trend in a lot of agencies, but it's been historical context.

DR. JEAN CAMPBELL: Twenty -- 20 years for the consumer survivor movement.

DR. VELMA MCBRIDE MURRY: And it's because of that there is this attention to voices and at these multiple levels. It's just an historical approach that is part of SAMHSA.

MS. HARRIET C. FORMAN: That's a whole generation.

DR. VELMA MCBRIDE MURRY: And other agencies -- and that could be a training template for other agencies because the other agencies are trying to teach whomever is part of those agencies how to do it, and SAMHSA, again, you know, it's been done. It's the model.

MS. SHARON AMATETTI: Okay. So we have run out of time. I really appreciate that everyone has stayed so engaged in this conversation the whole afternoon.

DR. VELMA MCBRIDE MURRY: This is great.

MS. SHARON AMATETTI: Johanna, do you want to maybe write some draft, and then we could hear it at the end of the day, or do you all just want to say go for it, Johanna, whatever you come up with, based on what we talked about or --

DR. SHELLY F. GREENFIELD: I just sent to your email what I wrote, just as a sketch out. So --

MS. JOHANNA BERGAN: What email did you send it to?

DR. SHELLY F. GREENFIELD: Whatever you published, your bergjo05.

MS. JOHANNA BERGAN: Perfect. Yeah, that's great.

DR. VELMA MCBRIDE MURRY: We'll be around. You know, most of us will have access to email. So it doesn't -- I mean, I'm okay. Whatever the group wants to do.

MS. IRENE GOLDSTEIN: I am charged with writing highlights of this meeting, and I propose not to stamp on the suspense and the thunder unless you think that there ought to be these points in highlights.

DR. VELMA MCBRIDE MURRY: I missed it.

MS. SHARON AMATETTI: I'm not following.

MS. IRENE GOLDSTEIN: I'll talk to you later.

MS. SHARON AMATETTI: Okay. I'm new at this stuff. We'll figure that out later.

MS. STARLEEN SCOTT ROBBINS: What support do you need, Johanna?

MS. JOHANNA BERGAN: I need Shelly's email to arrive in my inbox.

[Laughter.]

DR. SHELLY F. GREENFIELD: Do you want me to send it again? Do you want me to send it again?

MS. JOHANNA BERGAN: No, that's okay. I'm not on, you know, wireless. So it will just take a little bit. It's here. I got it. We're good.

DR. SHELLY F. GREENFIELD: Okay, yes.

MS. JOHANNA BERGAN: Okay. Now do you -- I mean, I'm happy to -- I have an intro to add to what Shelly wrote, and then a little bit about --

DR. SHELLY F. GREENFIELD: I did not wordsmith this at all. I just --

MS. JOHANNA BERGAN: Yeah.

DR. SHELLY F. GREENFIELD: I wrote out "since there's a long history" and "in

the future should continue to use multiple lenses, trauma, women's, recovery, and gender-specific services." And then added in some of the other things that we talked about, including "SAMHSA can provide the education at the organizational level to ensure that initiatives include behavioral health."

So that's the two things I added to what I read to you before. I didn't get the practice-based evidence in there.

DR. VELMA MCBRIDE MURRY: I'm willing to break later if you need us to.

DR. SHELLY F. GREENFIELD: Do you want me to read this? Do you want me to read this in 2 seconds, and then just have people respond?

MS. JOHANNA BERGAN: Sure.

DR. SHELLY F. GREENFIELD: Okay. So the --

DR. VELMA MCBRIDE MURRY: Except we don't have your introduction to it.

MS. JOHANNA BERGAN: Well, she put in a sentence.

DR. VELMA MCBRIDE MURRY: Oh, fair enough. There you go.

MS. JOHANNA BERGAN: So it's not -- yeah. I think, Shelly, go ahead and read that.

DR. SHELLY F. GREENFIELD: I'll read this, and then you can add the pieces that are missing from what we said.

DR. VELMA MCBRIDE MURRY: Okay.

DR. SHELLY F. GREENFIELD: SAMHSA has a long history and in future should continue to use multiple lenses, such as trauma, women, recovery, and gender-specific services. The SAMHSA of the future is a public health organization uniquely representing the need of a continuum of services for behavioral health. In representing these needs, it will support/implement the translation of research to practice and diffusion and scalability.

SAMHSA can partner with other organizations to leverage resources to accomplish its mission of diffusion of evidence-based practices from primary prevention, to treatment, to recovery, to facilitate the health of the public. SAMHSA can provide the education at the organizational level to ensure that initiatives always include behavioral health.

I added "always" just now.

DR. JEAN CAMPBELL: I don't think we have the public health vision --

FEMALE SPEAKER: Yeah, that's not in there.

DR. JEAN CAMPBELL: -- in what you wrote, and I thought "multiple lenses" could mean almost anything.

MS. JOHANNA BERGAN: Right. So I have -- I have further information here about recognizing SAMHSA's many years of and history of involving consumer experience, and that these tables -- these voices are not heard at other Federal tables and that something about this uniqueness, that should be included in that beginning. This uniqueness serves as an expertise.

DR. JEAN CAMPBELL: But the public health --

DR. SHELLY F. GREENFIELD: It says the SAMHSA of the future is a public health organization.

DR. JEAN CAMPBELL: Oh, okay.

DR. VELMA MCBRIDE MURRY: Yeah, it did say that.

DR. JEAN CAMPBELL: Oh, okay. I missed it.

DR. SHELLY F. GREENFIELD: My computer just froze --

MS. SHARON AMATETTI: So I think are we all happy with that for now, for right now? Okay. Great. Great work, Jean. Yay, good.

All right. I'm going to give you a 10-minute break, okay, everybody? And we'll come back at 10 past the hour.

[Break at 4:01 p.m.]
[Reconvened at 4:12 p.m.]

MS. SHARON AMATETTI: Why don't we go ahead and get started then, okay? Shelly very generously agreed to share her work with us on the Women's Recovery Group Study, and I appreciate especially that you did this knowing that you were going to be away right before our meeting and got this all prepared for us.

DR. SHELLY F. GREENFIELD: Thank you.

MS. SHARON AMATETTI: Let me turn it over to you to introduce your work.

Agenda Item: The Women's Recovery Group Study

DR. SHELLY F. GREENFIELD: Sure. And I wanted, actually, to thank you for the opportunity to present the work to this group.

So what I'd like to do, and the 4:00 p.m. slot is not the enviable speaking slot. So I'll strive to keep you all awake. I'll do my best.

[Laughter.]

DR. SHELLY F. GREENFIELD: But, and you'll pardon me for moving my head to the screen and back to you as I do that, but I'll need to do that.

So the other thing I just wanted to tell you is in the binders under the tab that has this, you have a copy of almost all the slides except the unpublished data, which I'll show you on the slides. But also four out of the seven published papers that exist, so that there are certain things I'll just gloss over really quickly, but there's more information in the binder. So you have the studies that are printed, and then there's a list of bibliography after that.

And in some ways, the most simplest way to just even introduce this beyond is that what we were striving for was to develop and test a women's recovery group that would be an all-women's group therapy that we could demonstrate was effective, that it would actually be one that would accept a heterogeneous group of women. And what I mean by heterogeneous in this instance are women kind of who typically come into community-based treatment programs who are heterogeneous with respect to the substance of abuse that they use and also with respect to their co-occurring psychiatric disorder.

So, basically, kind of what the kinds of folks who are coming into general community programs. And when we went to look for -- I wanted to test something else, and I went to look for an evidence-based group therapy to utilize, I discovered about 10 years ago that there wasn't one. So we started down this path to develop one, and now this is about 10 years later, and we're just concluding two phases of the study.

And so, now I'm going to present that work to you. So that's in a nutshell what you're essentially going to hear.

And so, just quickly, I just want to acknowledge the generous support of the National Institute on Drug Abuse for this work and also just to let you know I don't have any disclosures of conflicts of interest.

And so, a lot of this is known to you that, basically, the focus of this is that compared with men, we know that women are initiating their substances, their

use of substances at much earlier ages. And actually, basically, on a one-to-one ratio with men, we know that they now have lower levels of abstaining overall and higher rates of abuse and dependence in recent birth cohorts compared to past, that they advance more rapidly from their first regular use to their first treatment episode. And that, basically, we call that the accelerated or telescoping course of illness. Use smaller quantities of substances for fewer years, but also in that setting actually have greater medical, psychiatric, and social consequences of their use.

And so, the most -- some of the most reproducible convergent evidence -- and there's a paper in the binder that just summarizes a lot of this -- that there is increased prevalence in women in the past two decades, a heightened vulnerability to the adverse consequences. This telescoping course, which has been shown in alcohol and then in cocaine and most likely as well in opiates and possibly in marijuana now. And at treatment entry with fewer years of use, women have more medical, psychiatric, and adverse social consequences.

So that was the background. In spite of all that, although this may be changing in the last 5 years, there's data that shows that the probability of actually entering treatment over the life course for women for their substance abuse is lower than for men, as all of you know. Actually, in general, men and women don't enter treatment overarchingly for substance use. It's put at about 10 percent total, or maybe up to 20 at the max.

One of the studies looking at alcohol showed 23 percent of men and 15 percent of women endorsed ever receiving any type of treatment, any, any, including just talking one time to a practitioner. And women, we know, may preferentially seek their care in nonsubstance abuse treatment settings, in primary care, in OB, in other settings, often saying -- talking about their depression or their anxiety or family-related issues, never really actually coming forth and talking about the substance problems that they have. Therefore, they're nonidentified and nontreated.

And so, we actually wondered that, given this heightened vulnerability, given that they don't necessarily seek care, what do we know in general about gender-specific substance abuse treatments? What's the rationale to have a gender-specific substance abuse treatment? And then what was the evidence base for gender-specific substance abuse treatment? So that's the background of how we kind of got into this to begin with.

And so, just quickly, we think about three rationales for women-only treatment. The first is the issue of individual differences and preferences, that certain women actually wish to have their substance abuse treatment in a gender-specific and women-only setting, and they won't actually seek that treatment unless they have that. So just -- and we also know that patient preference actually plays a role in outcomes overarchingly. So that's number one.

Number two, we know that there are effects of gender on group process. And in fact, that short-term groups can be more cohesive by certain types of homogeneity, including gender, we think. But also some of the qualitative work, and ours now also supports this, women often cite preferences for women-only groups because they say they have an enhanced freedom to speak openly. That the gender composition actually has an effect on group process, that there's decreased sexual stereotyping, and that they -- that this enhances their experience and their ability to gain treatment.

And then, finally, in a gender-specific, women-focused group, you can actually address certain topics that are specific interest, and not just interest, actually very important in women's treatment and recovery, which include things like substance abuse and reproductive health, the effect of substances on women's health, in particular parenting and family relationships. And these are things we have a lot of evidence that women cite as important in their recovery, and we actually know from data that it is.

So interestingly, just to mention, a single-gender format may be necessary for this, but it's often not sufficient. So there's actually a study that was done. It was a natural experiment of a residential program. They were both mixed gender. There was a change in sort of the way in which they were going to be funded. They had to have a women-only treatment program. They changed no other aspects of their program, except they made it single gender, same program.

And what they actually found was there were no differences between the mixed-gender and the single-gender program. And there's been other evidence to show that just changing the gender from mixed to single isn't necessarily enough. It may a sufficient -- it may be necessary, but not sufficient, and that in general, the effective programs are gender responsive and address women's specific needs. That meaning that they incorporate the gender differences that we know in both in the antecedents of substance abuse and also the consequences into the treatment process.

And those things include many of the things we've talked about extensively here. The fact that women have a higher prevalence of co-occurring other psychiatric disorders, trauma exposure, the relationship with physical and mental health needs. And then again, another aspect of things that figure centrally are women's relationships with children, intimate partners, and other individuals in their social network that actually play large roles in their addiction and recovery.

And finally, that full gender-responsive treatment programs tend to provide adjunctive services that we know make a very large difference in overarching outcome. I'm not going to read this list. You know all about it. These are some of the things. So that whole programs will -- that are gender-responsive will provide.

What we were really looking at was this idea of elements of treatment, like group therapies, and what we found was that there were previous studies of women-only groups. But they were for very specific subgroups of women, such as pregnant and parenting women, women with co-occurring PTSD and substance use disorders, patients with borderline personality disorder who are abusing substances, incarcerated women with substance use disorders. And as I said, in community treatment, often programs have women coming into treatment who are heterogeneous with respect to many of these things.

So group therapy is the mainstay of a lot of our treatment programs, and as I mentioned earlier today, it's a cost-effective way of delivering treatment. Most women actually receive their treatment in mixed-gender programs. And so, we were -- we were interested in the need for a specific replicable, manual-based group therapy designed for women with substance use disorders who are heterogeneous with respect to those things. And that is where we started with this women's recovery group.

I think I just want to say --

MS. SHARON AMATETTI: Do you want to just pause here, see if there's any questions --

DR. SHELLY F. GREENFIELD: Yes, I will pause. I'm trying to be very respectful of the time, the hour, not keeping people. So I'll take a breath. Are you with me so far? You know a lot of this background.

MS. JOHANNA BERGAN: Yeah, this is cool. So is there -- you had mentioned earlier in a comment that I had made that there is information and knowledge about the importance of gender-specific groups. And here you've also said that it may be necessary to switch a group to gender specific, but that might be not -- that's not enough?

DR. SHELLY F. GREENFIELD: Yes. So let me -- let me continue on. But the basic thing that I was trying to say, and I'll show you in a moment, when we did this trial, we randomized people for this all-women's recovery group, and we randomized women into mixed gender. And we did exit interviews about -- that were qualitative about their experience. I'm going to show you that data, and it will show that what they were able to address was different between the two groups.

So, yeah, go ahead.

MS. JOHANNA BERGAN: So have you made any speculative jumps about applying not necessarily substance abuse support groups, just in general when we provide, I'm thinking peer-to-peer. When we create supportive groups, is

there somewhere to point people to the benefits of having gender-specific groups?

DR. SHELLY F. GREENFIELD: So can I go back and around?

MS. JOHANNA BERGAN: Yeah, please do.

DR. SHELLY F. GREENFIELD: Because the question you're asking is really an important question, and I think I'll be able to kind of answer it a little bit better when I present some of this.

MS. HARRIET C. FORMAN: I'm sorry. This is a basic question. What does it mean, heterogeneous with respect to their substance disorder and co-occurring other psychiatric disorders?

DR. SHELLY F. GREENFIELD: So what I mean by that is so if you're in a treatment program and you're receiving women into your treatment program, you will often get somebody -- you'll get a range of people. Somebody, their primary substance is alcohol. Another person's primary substance is opioids. Some people have opioids and alcohol. Some have a major depressive disorder. Some have PTSD. Some have a trauma history.

But they are all coming to receive treatment in one program. So if you only have a group that's specific to people who had trauma, what are you going to do with these other women who don't have a trauma history? If you are only providing treatment for someone with a co-occurring depressive disorder, what are you doing with these other folks?

And so, the question was how would you provide something that's gender responsive that would actually accommodate all of those needs? Because in our treatment programs, that's what we are receiving into community-based treatment. It's, you know, people don't segregate themselves out that way. They just come as who they are. And the question is how can you provide an evidence-based group for them that would actually take into account the heterogeneity of those needs? Does that make sense?

DR. JEAN CAMPBELL: So could some be pregnant and some old and some --

DR. SHELLY F. GREENFIELD: Absolutely. And I will show the range of ages was from --

DR. JEAN CAMPBELL: Some married, some not.

DR. SHELLY F. GREENFIELD: Yes, exactly.

DR. JEAN CAMPBELL: Okay.

DR. SHELLY F. GREENFIELD: All of those. The demographics, and in fact, the beginning --

DR. JEAN CAMPBELL: Rich, poor.

DR. SHELLY F. GREENFIELD: The beginning phase or the beginning -- at the very beginning of this, people said, well, you can't put a 22-year-old in the same group with a 69-year-old. You can't put a such and such in, and actually, that's not really what we found. And we would have people who, you know, marijuana -- I'll show you. I mean, that's what I'm going to show you.

[Laughter.]

DR. SHELLY F. GREENFIELD: That's what I'm going to show you. Exactly.

MS. SHARON AMATETTI: Is this outpatient, residential? What are we --

DR. SHELLY F. GREENFIELD: So we did this as an outpatient group, and that's -- so funny you should ask. So, in fact, what we did, I just want to say we developed -- we've been doing this for 10 years now. So we developed this for -- initially for outpatient, and when we did that, we did it -- and I'm going to tell you about that. We did it one way because we were developing the treatment. And in order to develop it and test it, that's how we could do it.

When we did the second phase where we were trying to scale it up, we did it actually in an outpatient program, two outpatient programs that were also embedded in a large -- larger program. And what we believe is in doing that, it means it can be now -- it could be inserted into any level of treatment. So you could put it on an inpatient unit. You could put it in a residential program. You could put it in a partial hospital program.

So we did it in two phases, and that's what I'm going to show you. I mean, what we were wanting to do when we first started was to develop this new manual-based group treatment. We wanted it to have two components. So, Johanna, to your question, it would have an all women's group composition, but we also wanted to have content relevant to women in recovery. And then we wanted to pilot test it and make sure it was feasible and acceptable and satisfactory to the patients.

And then in stage two, if stage one was effective, then we wanted to scale it up and test it in a larger sample. So I'm going to show it to you in this way. We wanted to know whether it would have patient acceptability and satisfaction. We wanted to know whether there would be any differences in the 12-week within treatment outcomes -- 12 weeks is the length of the treatment -- compared to a standard mixed-gender group. And then we also wanted to know whether 6

month downstream we would see any differences in outcomes.

And so, this is the hypothesis we had as a mechanism of action. We said there'd be two ingredients. That's how we think of it. An all-women's group composition where that we thought would increase group cohesiveness, increase an open discussion of triggers and relapse prevention, and increase comfort and support. But also there would be women-focused content and education about antecedents of substance abuse that differentially affect women and also consequences in recovery. We thought that those two elements would synergize and enhance the outcomes for the women. So that was the theory.

This is a 90-minute structured relapse prevention group therapy. It's a manualized therapy. The therapists are trained to provide it. It includes a brief check-in, a review of a skill practice from the previous week, a presentation of a topic, a discussion by the participants, a review of take-home messages. Then you're given another skill practice for the coming week, and then there's a checkout.

And so, we developed 14 session topics based on the literature at the time, and the ones I've highlighted in blue are the ones that are gender specific. The ones in black are very standard substance abuse treatment topics, but within them, there is content that's gender responsive. So the ones in blue you can see the effects of drugs and alcohol on women's health; managing mood, anxiety, and eating problems without using substances; violence and abuse, getting help; women and their partners, their effect on the recovery process; women as caretakers. Can you take care of yourself while taking care of others?

Women's use of substance over the life cycle; substance use and women's reproductive health; the issue of disclosure, to tell or not to tell, to address shame that many women have; and then other, once again, as I said, are very standard, but we have put into that gender-responsive content.

So -- yeah?

DR. JEAN CAMPBELL: Could you give an example of what a skill practice would be?

DR. SHELLY F. GREENFIELD: So a skill practice could be anything from if you're confronted with a high-risk situation, how would you manage that? So, for example, you have a trigger that is something that might move you toward being vulnerable to use. What might be -- can you think in advance of three things that you would do rather than actually use, you know, a drug or alcohol in that circumstance? It could be anything from avoiding the circumstance --

DR. JEAN CAMPBELL: So would that be homework or --

DR. SHELLY F. GREENFIELD: It's homework, exactly. It's homework.

DR. JEAN CAMPBELL: And so, they would think of three things?

DR. SHELLY F. GREENFIELD: And bring it back in the next time. Exactly. And it's discussed briefly at the beginning of the session. And there are -- there are a whole variety of things like that.

So we used an effective mixed-gender group drug counseling, which has been used in other studies and is meant to most represent standard group drug counseling in our community programs. That's what we did a randomization against. And we looked at the women in the women's recovery group and the women in the group drug counseling, and we hypothesized they'd have better treatment outcomes with fewer days of any substance use, fewer drinking days, fewer drinks per drinking day, greater improvement in addiction disparity index. These are standard outcome measures that are used in the field.

I'm just going to show you from the Stage I trial, this is a picture that looks very complicated, but actually when I explain it to you, I think it will be pretty obvious. And this is very handy that I have a rolling chair.

[Laughter.]

REPORTER: Actually, you need to be closer to the table.

DR. SHELLY F. GREENFIELD: I do? Oh, then it's not so handy. Okay. So I'm going to talk it to you.

So on the Y-axis is improvement, meaning that's everybody getting better. And to the left-hand side, that's all the women in the women's recovery group, just if you focus on those bars, for simplicity's sake. And then on the right-hand side, those are the women in the group drug counseling condition.

The blue bars are the 12 weeks in treatment. And what you can see is the women in the women's recovery group and the women in the group drug counseling all improved in treatment during these 12 weeks that they were in treatment. What we found really interesting about this particular very small trial, with very small numbers, 36 women, was that in the 6 months post treatment, which are the pink bars, the women in the women's recovery group were maintaining or increasing their gains and continuing to improve, and the women in the group drug counseling actually worsened.

So that was the thing that really intrigued us, and we also found from a pilot client satisfaction scale that everybody was satisfied with their treatment. And this is a standard measure on the client satisfaction questionnaire that basically most people are satisfied with their treatment. But in this instance, the women in

the women's recovery group reported some enhanced satisfaction over the group drug counseling.

This was a tiny, tiny trial. We were curious about why this could have happened. There is a paper in your binder. So I won't go through this. But we looked at self-efficacy, and we were interested in whether feeling like you would be successful would predict your outcome, which has been shown in other healthcare things to actually be very relevant in alcohol and drug treatment.

If you feel like you're going to be successful and you think you will be, often you are. And those people who are reporting at the outset that they don't feel like they can do it often know something about themselves that we should be paying attention to.

What we found really interesting here is that, and I'm going to explain this to you, again, if you can reverse your mind, the bars going down are better. The bars going up are worse. I wish I hadn't done it this way, but I did. So what this is about is self-efficacy, and what we found is that women with high self-efficacy, whether you were in -- so it says WRG, GDC high and WRG high. All of those folks actually got better and sustained their gains overall. What we found was that if you had low self-efficacy, the women who were in the women's recovery group, they're the ones who did the best. And if you were in the mixed-gender condition, you did the worst over time.

So we wondered about whether it was really these vulnerable women who were actually contributing to the effect that we saw. Again, the trial is so small -- yeah, go ahead.

DR. JEAN CAMPBELL: I was just going to add that self-efficacy is a positive psychological outcome.

DR. SHELLY F. GREENFIELD: Totally. Absolutely. And it's used -- there are many scales, but there's a particular scale that we use that's been used in alcohol treatment studies that really shows it actually is a fairly positive predictor of treatment outcomes.

So one other thing, and this speaks a little bit to what Johanna was asking. We also exit interviewed everybody. We taped the interviews. We asked them about their experiences, and then we analyzed them using qualitative methods. And the women in the women's recovery group stated that they were able to focus on gender-relevant topics as compared to GDC, and also compared to GDC, they more frequently said that they endorsed feeling safe, embracing all aspects of themselves, having their needs met, feeling intimacy, empathy, and honesty in the group setting.

And there is a paper, it's a complex paper, it has a model in it. And that's in the

binder. So you could just see what the qualitative analyses of that were.

So we concluded that this was a manual-based treatment. It had high satisfaction, and what I'm going to explain to you is a semi-open group format, we actually saw some reductions that were equivalent to the standard mixed-gender treatment during treatment. But we saw some gains continuing in the 6 months post.

The problem with this was that it was so small, such a small trial, and also the way we did it was just slightly artificial. And this is sort of the way in which I think, you know, practitioners become frustrated by researchers who do things that aren't exactly shelf-ready, out to go into the community.

Because what we did was we did what we call a semi-open group, which meant that let's say a group needs eight people in it. So when we were recruiting people into the study, we would recruit for the first 3 weeks until we got to the 8. So maybe 3 weeks in, we would get to the 8. We'd start it, get to eight. Then we'd run it all the way until it was done, be done, get their outcomes, start the next group.

That's not how treatment works. Treatment does not work like that. Treatment works where the groups just roll continuously. So people are coming in. They're doing their thing. They're going out. Then they're rolling in and doing.

So we didn't feel like this was shelf-ready, and we wanted to see whether we could replicate any of this or get good outcomes in an open, rolling group format, which would make it, you know, practice ready. So that was the impetus for the second trial, and as I said, we were fortunate that NIDA funded us to do this in a larger two-site -- and we actually used one of our community partners through the Clinical Trials Network at NIDA in an economically challenged part of southeastern Massachusetts, SSTAR. And we partnered with them, and we ran it at two sites.

So we wanted to see if we could replicate, but also do it in a rolling format. What I really want to tell you is if you think about it, one of the things we hypothesized was this cohesiveness that the women would get by constant attendance. When you put it into rolling admissions, you also decrease cohesiveness because people are only with the same group for maybe four sessions, and then they've got some members coming out of the group and then some new members coming into the group.

So just that is a very standard way practice is practiced, and we used the standard practice format. I just want you to keep that in mind because I think it's actually kind of important. I just told you what I just said, which is nice because we can go to the next slide.

So we conducted this, as I said, in two sites. SSTAR is in Fall River, Massachusetts in McLean, which is in the western suburb of Boston. Half were at McLean. Half were at SSTAR. We expanded the eligibility with regard to co-occurring disorders. We excluded psychotic disorders and people with active bipolar I disorder. We also excluded current IV heroin because they would need more than just a single group, which this study allowed you to only be in a single group if that was what your treatment was.

We enrolled 158 people, 100 women and 58 men. And this is not in your binder, but the total enrollment, as I said, was 158. The mean age was 47, with a range of 23 to 79 years. So this was a big range of people. They were mainly white. We actually had a lot of Portuguese and English as second language. They don't standardize to this, you know, based on ethnicity. Thirty-two percent were married; 35 percent were divorced and separated; 25 percent were never married.

And we think that these are fairly generalizable in terms of folks who come to treatment. Eighty-eight percent had alcohol dependence, 17 percent opioid dependence, 15 percent cocaine dependence, 9 percent sedative dependence, and 9 percent cannabis dependence. Many of these women had multiple dependencies.

Sixty-one percent had a major depressive disorder, 22 percent generalized anxiety disorder, 20 percent PTSD, 75 percent in total had any Axis I disorder, and 17 percent had any Axis II disorder. And we're one of the few studies that actually measured personality disorders in this. Often that's left out of the picture.

And this is what we found. We found that the women's recovery group in the first phase of treatment, people had significant reductions in their mean days of any substance use from a mean of 18 days of use when they came into treatment, down to 2 days of treatment on average. And this was not significantly different than the mixed-gender condition, but we also found that people sustained their gains in the entire treatment phase and 6 months post. That's pretty decent outcome.

And here's a plot of mean days of alcohol use, which was the same. This was any substance use, and this teased out the alcohol.

So to wrap up, and then we can discuss more if you want, we think this is a -- we think that this has shown it is a new manualized group therapy for women. In the Stage II trial, both WRG and this mixed-gender GDC demonstrated clinically relevant reductions in substance use during the 3 months treatment and 6 months post treatment. The women-focused WRG, we think, therefore, is effective treatment for women with substance use disorders who are heterogeneous with respect to their substance and their other co-occurring

disorders.

And what we think we showed was that you can effectively implement this now in an open, rolling group. We ran these groups for 24 months with no break. So we had backup therapists. So when people went on vacation, they never stopped. We just kept going, and we kept entering, just like treatment does. So, and as I said, these are very real-world practice settings.

This is a lot of little writing, but I'll just summarize that what we're really seeing here is that we think we were able to match an effective community-based treatment. We think that this actually provides a gender-responsive, women-focused group, that you can utilize and deliver in a mixed-gender setting.

There are differences in the Stage I and Stage II. We didn't see it outperform the mixed-gender condition, but we actually wonder whether that has something to do with this fluctuating attendance and the fact -- and in our exit interviews, the women actually reported that they wished some of the women had stayed, that they didn't really like the -- you know, the transition of the attendance in the group.

As I said, from an implication for treatment, the group treatment is a mainstay of substance abuse treatment. Groups are generally -- treatment is generally delivered in this rolling format, and most community-based programs deliver treatment in mixed-gender settings. And we think this can now be an element of treatment that can be delivered as a gender-responsive treatment for women and as a component of their treatment in mixed-gender treatment.

And speaking of voices, I'd like to actually give you some of the women's voices that come from this. I just chose two excerpts from our exit interviews from two women.

One said, "Women tend to come from a different point of being where we are caretakers struggling to do all things for all people. And there's sexual abuse, there's eating disorders, there is this and there is that that really pertain specifically to women, and women experience the stigma of alcoholism in a different way than men do. There are just a lot of reasons why women can together explore the subject of alcoholism in a different way than a mixed-gender group or a male-based group."

And then another said, "A lot of information that was presented to me, I was very unaware of. In particular, women's health and what alcohol does to a woman's body. The education end of it was huge for me, really huge, to the point that I was sharing it with my family and friends."

And this other stuff you actually already know. So just with tremendous thanks to this huge number of people who helped on the study over the last 10 years,

these are some of them in the picture. And that's where I work, and thanks for your attention at the end of a long day.

And I just tried to rocket through a lot of information. So to provide you some of the basics, but I'm happy to talk.

Agenda Item: ACWS Discussion

DR. VINCENT J. FELITTI: I've never heard the term "manualized," I mean referring to?

DR. SHELLY F. GREENFIELD: So manualized treatments are actually really kind of a mainstay of behavioral treatment in both mental health and substance abuse. And actually, the NIH, many of the large treatment trials that have implemented group treatments actually constructed manuals that you can actually get online.

DR. VINCENT J. FELITTI: Oh, oh. Okay. I see.

DR. SHELLY F. GREENFIELD: So a manual is actually something that you can use to replicate the treatment wherever you go.

DR. VINCENT J. FELITTI: Right. Gotcha.

DR. SHELLY F. GREENFIELD: One thing I wanted to say to I think it might have been Administrator Hyde who said this, I think it was. One of the things that we think in terms of the results that we got -- and we're in the process of finishing the paper so we can submit it -- is that, you know, we supervised by phone. We did it all by phone because people were at different sites. But we gave everybody in both groups supervision weekly.

And you know, it's on the face of it, you might think that's, you know, a lot of labor to pay for. I think if you take two steps back and you think about making treatment maximally effective, I think it's a pretty small price to pay. You know, we actually provided -- I personally listened to every single 90-minute session. Everything was recorded. I listened to every single one of them and provided feedback, as did the other supervisor.

You don't necessarily need to do that, but this way we were able to make sure that the treatment was being delivered the way it was supposed to be delivered, and we scored it --

DR. JEAN CAMPBELL: For fidelity to the model.

DR. SHELLY F. GREENFIELD: Complete fidelity. But I think what you see is when you're delivering the treatments where there's fidelity to the treatment model, you actually get a much bigger bang for your buck.

DR. JEAN CAMPBELL: Exactly.

DR. SHELLY F. GREENFIELD: And I think we backed away from being able to supervise people, and I think in these research models, you can provide that. I just want to -- that's another point. It's to the -- maybe to the side of the point, you know, the overarching point. But I think it's a big, critical point in how we deliver services.

DR. JEAN CAMPBELL: I wouldn't have that as an aside because if you don't have fidelity to the model, then you can't guarantee the outcomes.

DR. SHELLY F. GREENFIELD: Exactly. Exactly.

DR. JEAN CAMPBELL: So it's critical for the effectiveness. I mean, if you don't have what you called supervision and I would call fidelity --

DR. SHELLY F. GREENFIELD: It is fidelity. We called it adherence. It's exactly right.

DR. CAROLE WARSHAW: There's fidelity, and there's supervision that how people deal --

DR. SHELLY F. GREENFIELD: Exactly.

DR. CAROLE WARSHAW: It's not just fidelity.

DR. SHELLY F. GREENFIELD: Exactly.

DR. CAROLE WARSHAW: It's the people developing their capacity to deliver it.

DR. SHELLY F. GREENFIELD: Yes. So just to -- can I just say -- I wanted to go back to what your point was. One thing that was really interesting in the exit interviews, so you know, when we advertised the study, we advertised it as just evidence-based treatments for -- group treatments for -- we didn't say we were doing women's treatment. It was just evidence-based group treatments. You could get it. It was at no cost to you.

And we would provide it, plus follow-up. So we didn't bias who was coming, and then we ran -- and you had to be willing to accept assignment. So we then randomize. And when we did the exit interview, so the women who were in the very excellent mixed-gender group drug counseling, they liked their treatment and they thought it was valuable. They actually said that it was valuable also to

sit with men and hear their perspective.

But they did also endorse that they were not able to share a number of other things and that they knew that there was another group. Because, you know, the consent form says you're going to be assigned to this or assigned to that. And so, many of them expressed an inability to share certain things. And I think when we listened to the tapes, we see it's so qualitatively different what's being shared.

And you can imagine that. I mean, if you are -- one of the big issues you have is something to do with your intimate relationships, and that's been a major part of why you are continuing to use, it is going to be very tough to express that in a mixed-gender setting with people you just met yesterday. And what's been really remarkable in listening to all these tapes is that, frankly, these women get right to that in the first session when they're together.

I mean, it's really quite remarkable. So that's -- you know?

MS. JOHANNA BERGAN: Yeah. I'm trying to apply this to a totally different setting. We're seeing something. We have 15 groups in New Jersey, teens, young teens. And some are successful. There was a group that was heavily male that recruited and sustained gender balance in a larger group by allowing space for males to meet and females to meet. And that then can bring them all together and still work.

There's a group that is almost all males. Females will come, but they will not have longevity in the group. And so, they're receiving support of can you give them their own space? And so, it's interesting to see this.

DR. SHELLY F. GREENFIELD: I think that replicates. It's interesting. When we were trying to figure this out, we had to go -- this is 10 years ago. We had to go to the education literature about single-gender classrooms to find any literature because there wasn't any literature on the single-gender format for treatment, if you can believe that. That was true.

FEMALE SPEAKER: Stephanie's stuff? Covington.

DR. SHELLY F. GREENFIELD: You know, again, it was at the time there was a manual, but there was no research to demonstrate or support it. And it wasn't done against a mixed-gender setting. So there wasn't -- you know, there really wasn't any research literature. It was any of the research literature came out of education.

And you know, we've been asked, well, what about citing literature on men? And the answer is there isn't in treatment. So, actually, that's one of the next things we also want to look at, and I know SAMHSA is doing some of this work as well.

But what I would say to you is people say exactly what you're saying. Women have had experiences of going to treatment where they were 1 of 10 or 2 of 10, and it doesn't work out that well for them. And often, they just vote with their feet.

And that's what I was saying about individual differences and preferences. Women may, if you think about it, if you're only going if you can be in a treatment setting with women and you're not going if it doesn't exist, then think of all the people you're not going to treat because they're not going to go, you know? Just like, you know, what you're citing.

Carole?

DR. CAROLE WARSHAW: Yeah. I was just wondering about other kinds of outcomes that you saw or differences because these -- alcohol use dropped for both of them.

DR. SHELLY F. GREENFIELD: And other days of drug use.

DR. CAROLE WARSHAW: Yeah. But other kinds of things that were --

DR. SHELLY F. GREENFIELD: So we're looking at all of that right now.

DR. CAROLE WARSHAW: Okay. Because I would think there would be other kinds of differences.

DR. SHELLY F. GREENFIELD: We have so much data, and we're in the middle -- we're actually looking at what's called the important people inventory right now. We're taking a look at everybody and their social network, whether they changed or not, whether they have users in their network. We have data on self-reported trauma we're going to look at. We have a lot of other both primary data and then also we are interested in did certain other things change? Like did their coping style change? Did their social supports change? You know, a whole host of things like that.

We're wondering whether the mediators of the outcomes between the two different kinds of groups made it different. And we have a lot of that data. We just have to look at it, which we haven't had a chance -- we haven't done it yet. We're doing it, but we're not done with it. So it's a great question, actually.

We also will look at functional outcomes because functional outcomes are actually very important and don't always -- don't always track with the substance use outcomes. Sometimes you see different predictors of functional outcomes and substance use outcomes. So sometimes different things predict those, and people don't always recover all areas at the same rates and paces either, as you know.

So, yeah, we will look at some of those.

DR. JEAN CAMPBELL: So I was going to –

[Telephone ringing.]

DR. JEAN CAMPBELL: Oh, my God.

DR. SHELLY F. GREENFIELD: Nobody ever calls you except --

DR. JEAN CAMPBELL: But I apologize.

DR. SHELLY F. GREENFIELD: Starleen, do you want to ask, and then --

MS. STARLEEN SCOTT ROBBINS: A couple of different things. One, thank you so much. Because for those of us who have been doing women's treatment for 20 years, thank you for proving that, one. But the other is that this also translates when the women go into the community, into AA and NA.

DR. SHELLY F. GREENFIELD: It does.

MS. STARLEEN SCOTT ROBBINS: Because if they've been in a women's group --

DR. SHELLY F. GREENFIELD: Right.

MS. STARLEEN SCOTT ROBBINS: -- in an effective women's group, they also don't feel comfortable in mixed-gender and then in the AA and NA groups.

DR. SHELLY F. GREENFIELD: Yeah, yeah.

MS. STARLEEN SCOTT ROBBINS: So there's also the kind of cultivating the women's groups for AA and NA in the community so that women can feel comfortable and have support with it once they leave.

DR. SHELLY F. GREENFIELD: Yes.

MS. STARLEEN SCOTT ROBBINS: But I had a question about the supervision. Is that built into the manualized treatment? Because that does seem like a key piece of and not just an aside, a key piece of this being something that's going to work in other places.

DR. SHELLY F. GREENFIELD: So, yes and no. I mean, in terms of the study itself, it was obviously built in. In terms of the -- so we've been moving the manual into a book, which, hopefully, will be out sometime in 2014. In that book,

we will publish sort of how you would measure adherence. There's an adherence measure that the therapists can themselves utilize, or if they have a supervisor, the supervisor could utilize the treatment programs, would need to, you know, decide how they were going to implement this.

But, yes, the adherence measures is part of the manual itself. I mean, that's a partial answer. But I think how you would deliver it, you know, you could, you would have to decide are you going to have somebody who's, you know, your expert who is going to kind of -- you know, kind of help people self-rate to adherence.

DR. CAROLE WARSHAW: What skills do people have who are delivering it? And could someone without clinical training deliver it with good supervision?

DR. SHELLY F. GREENFIELD: So I don't know the answer to that question. I mean, I would say that these were all -- because it was a study, these were all people who had, you know, at least, you know, 3 to 5 years of, you know, training. They were all at master's level folks.

But our other kinds of work that we've done have shown that we've been able to translate these types of therapies towards counselors who don't have advanced degrees, and I don't think there would be any reason why you couldn't train up. But we don't -- we didn't do that. So I can't really answer that in a reverse way.

DR. JEAN CAMPBELL: I have been field testing a fidelity tool for peer practices based on a multisite study, and I would recommend -- it's been 5 years now. So now I'm thinking of the conclusions and what we learned. And one thing was what do you do with the adherence measure? And what we did was share it back to the program and -- but I really didn't follow through with any sort of model or support for how they might make changes for improvement. Some did, some didn't.

And what I'm now doing is developing a CQI process. I'm going to do a webinar training now with the sites. And so, it might be something --

DR. SHELLY F. GREENFIELD: That's a great idea.

DR. JEAN CAMPBELL: -- to consider because CQ, then you can have continuous quality improvement of the process to -- for the -- for the adherence, which is part of a component of supervision.

DR. SHELLY F. GREENFIELD: That's a great --

DR. JEAN CAMPBELL: The best of supervision.

DR. SHELLY F. GREENFIELD: That's a great idea.

DR. JEAN CAMPBELL: Mentoring. So it's a good model because it implies the testing component, the doing component, the training component. You know, it has the four steps.

DR. SHELLY F. GREENFIELD: Yes, yes.

DR. JEAN CAMPBELL: So, as a model, that might be something to -- and you wouldn't have to test that. That's how you would -- somebody would utilize the model.

DR. SHELLY F. GREENFIELD: Right. That's a good -- that's a great suggestion.

I just wanted to mention two things that we're doing. You saw 14 topics. We ran it initially with all 14 topics, and then the second round we just had 12 sessions. And what we did was we excluded two, but we actually have written the sort of manual to suggest that you might -- if you have 12 sessions only, you have 14 modules that you can choose from. So for your population, you may choose to exclude a module that might not be relevant to your population.

You also, if you were running it for 24 weeks, you might actually decide you want to spend two sessions on each module. It's very flexible in that way. And what we're going to do is we're about to start a pilot where we're going to be running this on our eating disorders program for our women with co-occurring eating and substance use disorders, and we're going to be collecting patient satisfaction on both ends and experience with it.

We're going to train up the therapists on that program because, as you know, the eating disorder population of women has a high co-occurrence of alcohol and drug issues, and actually, it's very hard to have integrated treatment. So we're going to take a first step within our own. And then we have one junior researcher who just received a small grant from our medical school to do focus groups with men to develop a male-specific group treatment on this model, but taking into account those sorts of needs.

And so, she's just launching that this summer, but we're interested in that side of things. And I actually shared the SAMHSA book with her so that she would have that as she kind of launches on that. She's got 2 years to accomplish that.

I would also tell you that when we asked women and men if they would prefer single-gender format versus mixed-gender format, on balance the women generally said they preferred single-gender format. When you asked the men, on balance they said they preferred mixed-gender format. And a lot of that, it's just -- it's a really interesting. It speaks to a lot of the things that we don't necessarily incorporate into our treatment approach about different ways that

people are acculturated in terms of how they can and can't discuss what their experience is.

And that's actually data for us to think about in terms of helping people be able to express what they need to express in ways that they can. So, yeah, Carole?

DR. CAROLE WARSHAW: I was just thinking about some of the kind of input from people who do batterer intervention and that men will be much more honest in a single with just men.

DR. SHELLY F. GREENFIELD: Yes, yes.

DR. CAROLE WARSHAW: Where they'll -- they may talk about feelings and other things with women, but there are things they won't talk about.

DR. SHELLY F. GREENFIELD: Right.

DR. CAROLE WARSHAW: So there's the accountability piece as well and so what they prefer and where they would actually be more honest.

DR. SHELLY F. GREENFIELD: Yeah, true.

DR. CAROLE WARSHAW: I was going to ask how you developed the actual content of the group.

MS. SHARON AMATETTI: You know, that's a really big question, and I'd only ask if we could have that, yeah, as a side conversation just because I just noticed it's 5:00 p.m., and it's been a long day of paying really great attention. That was so interesting, Shelly. Thank you very much for --

DR. SHELLY F. GREENFIELD: You're very welcome. And again, thank you for the opportunity to share the work. I'm happy to do that.

MS. SHARON AMATETTI: And I also appreciate that you provided the copies of your published articles that are in our binder as well, and so everybody feel free to follow up with Shelly with any additional questions. And thank you again.

DR. SHELLY F. GREENFIELD: You're welcome. My pleasure.

Agenda Item: Public Comment

MS. SHARON AMATETTI: We are at the point in our program now where we are to see if we have any persons on the phone who want to make any public comment, and we can ask Julie, our operator, and Josh is saying no.

MR. JOSH SHAPIRO: I've already asked.

MS. SHARON AMATETTI: That there are none. We have guests from NASADAD here, and we'll ask them if they have any public comments further for us. No?

Agenda Item: Closing Remarks/Adjournment

MS. SHARON AMATETTI: Okay. All right. Well, we have just a few minutes them. I would ask this esteemed group if you have any last final thoughts for today. I thought this was a really great day. Appreciate your active participation today.

Carole?

DR. CAROLE WARSHAW: One of the issues that you raised last time that we've raised is how being on the committee could actually help play more of a role and focus on the SAMHSA particularly around these issues. So I don't know if you all --

MS. SHARON AMATETTI: Well, I think today was partly a response to that with having the Administrator here to have this conversation.

DR. CAROLE WARSHAW: That was --

MS. SHARON AMATETTI: Yeah, and have input with the SAMHSA Women's Coordinating Committee. I do send you emails periodically about things that are going on, and I do want to have your input onto the development of our adolescent webinars that I mentioned this morning, and those types of opportunities come up periodically, but on a recurring basis.

There are some rules about how we convene and meet together that Geretta explained last time a little bit. So it's a little bit complicated. But I was really glad that we had the Administrator here today and that we had that conversation. That's important.

DR. CAROLE WARSHAW: Yes, that was great.

MS. SHARON AMATETTI: For next time, the next time we meet, I think I've heard very resounding that you would like to have a focus on wellness and health. We'll look at incorporating that into our next agenda, that recommendation.

Are there any other topics that you all would really like to have time to discuss?

DR. JEAN CAMPBELL: Could we have a speaker come in? Would that be possible or even by phone? Because I have a recommendation or a couple of recommendations. One would be Ron Manderscheid. I shared with you the work he did in the subcommittee for CMHS on the research and evaluation of wellness measures. But then Carol Ryff, who's a psychologist --

REPORTER: Please stop. You're banging on the microphone.

MS. SHARON AMATETTI: Okay. We're good now.

DR. JEAN CAMPBELL: Carol Ryff, who has written a lot of material in the field about the promotion -- the promotion of wellness and just some excellent, excellent articles. I really admire her work. It was instrumental in my conceptualization in my multisite study.

MS. SHARON AMATETTI: I think those are good. I'll follow up with you next time.

DR. JEAN CAMPBELL: Yeah. There might be others, but those two would be good.

MS. SHARON AMATETTI: Okay, good. I'll share that with Kana.

Harriet, did you have -- no? Nothing else? Well, feel free to communicate any of your ideas and thoughts for next time.

And I wanted to also say to our retiring members to feel free to communicate on an ongoing basis as well and don't become strangers because you're part of our immediate past members. Is that what --

[Laughter.]

MS. SHARON AMATETTI: Immediate past president. So we're really delighted, and it's a pretty exclusive club. So you're still part of that.

And otherwise, I think we are adjourned for the day.

DR. JEAN CAMPBELL: Can we leave our binders here?

MR. JOSH SHAPIRO: Yes, so if you want to leave your binders, I'll put them in the Joint Council room for tomorrow. If you want to take them, you can take them. It's totally up to you.

MS. SHARON AMATETTI: Nadine, do you have any last announcements that I

might not be aware of?

MS. NADINE BENTON: I do want to remind you to fill out your honorarium and, if you would, get that to me tomorrow at dinner time when we're at the joint meeting.

DR. VELMA MCBRIDE MURRY: And we're to be ready tomorrow at what time, the same time?

MR. JOSH SHAPIRO: So same time. So there's also going to be a shuttle picking you guys up at 5:15 p.m. right out here to take you back to the hotel.

MS. SHARON AMATETTI: That's pretty soon. It's good that we ended on time.

Okay. Thank you, everybody. I hope you enjoyed the day. I know I did.

[Whereupon, at 5:05 p.m., the meeting was adjourned.]